PEDIATRIC & ADOLESCENT
HEALTH PARTNERS

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Authorization for Medical Information Release

_____ (Print Patients Full Legal Name)

_____ (Patients Date of Birth (mo/day/year)

_____ (Street Address Where Patient Lives)

_____ (Home Phone Number With Area Code)

_____ (City, State, Zip Code)

_____ (Alternate Phone Number With Area Code)

I,_____ do hereby authorize the release of: _____**All Reports**
Patient, Parent or Legal Guardian

_____Discharge Summary	_____Pathology Reports	_____Emergency Reports
_____History & Physical	_____Laboratory Reports	_____Other Hospital Reports
_____Progress Notes	_____Radiology Reports	_____Other:_____
_____Operative Notes	_____ECG/EEG/Cardiac Cath	_____

___I Do ___I Do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Information released from another office:

_____

_____

_____

***To Pediatric and Adolescent Health Partners, P.C*:**

____ Midlothian Village, 13821 Village Mill Drive, Su. A, Midlothian, Va. 23114
Office:(804)794-2821; Fax:(804)794-4072

___ Bon Air Building, 8719 Forest Hill Avenue, Richmond, Va. 23235
Office:(804)794-2821; Fax:(804)320-4634

___ Powhatan Building, 3864 Old Buckingham Rd. Su. B, Powhatan, Va. 23139
Office:(804)794-2821; Fax:(804)372-9317

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorization is furnished, may not condition the treatment of the patient on whether or not this authorization is signed.

_____ **Signature of Patient (over 18 yrs old), Parent or Legal Guardian**

_____ **Date of Signature**