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Authorization for Medical Information Release

____________________________________ (Print Patient's Full Legal Name)

____________________________________ (Patient's 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 to another office: ____
____

From Pediatric and Adolescent Health Partners, P.C.:

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

□ Powhatan Building, 3864 Old Buckingham Rd. Suite. B, Powhatan, Va. 23139
Office :(804)794-2821; Fax:(804)794-4072

Reason for leaving Pediatric and Adolescent Health Partners, P.C.:___________________________________
____

_____Please initial here, if you would like a paper copy. The charge for a paper copy will be $0.50 per page for the first 50 pages and $0.25 per page for each additional page, plus the standard postage rate.

______Please initial here, if you would like your chart placed on a Disc/USB thumb drive for a $25.00 fee plus the standard postage rate. (Please be sure the location records are being sent to accepts Disc/USB thumb drives)

____________________________________ (Print Responsible Party-Full Legal Name)

____________________________________ (Print Patient's Full Legal Name)

____________________________________ (Billing Address)

____________________________________ (Relationship to Patient)

____________________________________ (City, State, Zip Code)

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**