Authorization to Release Medical Records/Information

Patient Name (s) ______________________________ DOB ____________________

______________________________ DOB ____________________

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Release Records ☑ FROM ☐ TO Release Records ☐ FROM ☑ TO

____	My Kid's Pediatrics and Adolescent Care
____	12011 Lee Jackson Memorial Hwy. Ste. 220
	Fairfax, VA 22033
____	Phone: 703-865 - KIDS (5437)
	Fax: 703-865-5889

By initialing in the spaces below, I authorize the release of the following medical records

_____ Clinician Office Chart Notes _____ Immunization History _____ Hospital Report

_____ Diagnostic Imaging Reports (X-Rays) _____ Laboratory Reports _____ Other: ____________

Purpose of release ☐ Changing Healthcare Provider ☐ Consultation ☐ Legal ☑ PCP Review

The medical information authorized above ☑ MAY or ☐ MAY NOT be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.

I request and authorize the above office or facility to release **ALL** of the selected medical records to the person or entity listed above. I understand that the information to be released may include, but is not limited to, the following conditions: drug abuse, alcohol abuse or alcoholism, sickle cell anemia, psychological or psychiatric conditions, AIDS or HIV status, and past medical history. I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re---disclosed and is no longer protected by those regulations.

I certify that this request has been made voluntarily and I can refuse and/or revoke this authorization in writing at any time, except to the extent that an action has already been taken to comply with it.

I understand this authorization will expire, without my express revocation, either one year after the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first.

Parent / Guardian's Name (print): ________________________ Relationship to Patient (s): ____________

Parent / Guardian's Signature: ___________________________ Date signed: ________________________