Authorization to Release Medical Records / Information

Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
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Release Records ☒ From ☐ To	**Release Records** ☐ From ☒ To
Name of Practice:	My Kid's Pediatrics and Adolescent Care 12011 Lee Jackson Memorial Hwy. Ste. 220 Fairfax, VA 22033 Tel: 703-865-5437 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: _____