PEDIATRIC ASSOCIATES OF ALEXANDRIA

Medical Records Release Form

Authorization for the Release of Protected Health Information

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. **There will be a fee for the requested records. Please allow a minimum of 1-2 weeks for processing.**

****PATIENT 18 YEARS OF AGE ARE CONSIDERED ADULTS AND THEREFORE MUST REQUEST THEIR OWN MEDICAL RECORDS*****

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

**** We strongly recommend records be sent to parents; if we should have to re-print your child's records there may be an additional fee.**

Providing Information:
Pediatric Associates of Alexandria
6355 Walker Lane Suite 401
Alexandria, VA 22310
Phone: 703-924-2100 ext. 202
Fax: 703-922-6067

Mailing Address:
Name:_____
Address: _____
City, State, Zip:_____
Phone: _____
*****Records will not be faxed.**

Specific Description of the Information to be Disclosed:

❒ **All Medical Records** ❒ **Specific dates of service, from: ___ /____/___ to ___ /___/____**

❒ **If records were brought from another medical office, would you like to receive a copy of these records? Yes___ No___**

All Records-Fee: $0.50 per page for the first 50 pages; $.0.25 a page for each additional page.

❒ **I would like my child's records mailed. I understand there is an additional $10.00 handling/mailing fee.**

❒ **I will pick up my child's records**

❒ **Digital Copy of Records ($25.00 for first record. $15.00 per additional sibling. Postage included in price).**

Reason for Release:

❒ Relocating ____/_____/____ ❒ Change Doctors ❒ Other, Not Transferring _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. I understand that I have the right to refuse to sign this auth.orization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office to the attention of the Privacy Officer. Absent such written revocation, this *Authorization Form for Release of Protected Health Information* will expire in 2-years from the date initiated below.

_____ _____

Signature of Parent, Patient or Guardian *Date*

_____ _____ _____

Printed Name of Parent, Patient or Guardian *Relationship* *Phone Number*