CHILD HEALTH ASSOC 45 NORTH HILL DRIVE #202 WARRENTON, VA 20186

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND NOTICE OF CHARGES FOR RECORDS RELEASE

(540) 347-0180 Fax (540) 349-3231

****** NOTE: There will be a charge for a personal copy of your records such as, when transferring care of records to a different provider, etc. Health Port has been contracted to provide this service and will invoice you directly for pre-payment. Virginia State Rates apply as pages 1-50 at $0.50 per page, pages 51+ at $0.25 per page, plus first class postage. ******

I hereby authorize disclosure of the health information for the named patient and agree to pay the charges as indicated above. 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 or 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 authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________ __________________ __________________________

Signature of individual or guardian **Date** **Contact Phone Number**
Personal Representative of patient's estate

______________________________ __________________________

(PRINT PATIENT'S FULL NAME) DATE OF BIRTH (MO/DAY/YR)

______________________________ __________________________

(STREET ADDRESS) SOCIAL SECURITY NUMBER

______________________________ __________________________

(CITY, STATE, ZIP CODE) PHONE (HOME)

____

(PARENT/GUARDIAN IF PATIENT UNDER 18 YRS OF AGE)

At the request of the individual, I ________________________, do hereby authorize **Child Health Associates** to release:
(Patient's name) (Name of Facility)

DATES OF ____

________Discharge Summary	_______Pathology Reports	_______ Emergency Reports
________History & Physical	_______Laboratory Reports	_______ All Records
________Progressive Notes	_______Radiology Reports	_______ Immunization Only
________Operative Notes	_______ECG/EEG/Cardiac Cath	_______ Other

_____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 RELEASE TO: ____
NAME OF COMPANY/AGENCY/FACILITY/PERSON

____
STREET ADDRESS

____
CITY, STATE, ZIP

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____LEAVING PRACTICE ____ LEGAL INVESTIGATION

_____DISABILITY DETERMINATION _____PERSONAL OTHER (SPECIFY) ______________________________

MEDICAL INFORMATION RELEASED BY HEALTH PORT

ENTIRE____ LAB ____ EKG ____
DS ___ EKG____ IMMUNE ______
OP ____ X-RAY ____ OTHER ______________________________
HP ____ PATH _____
____

____
ROI SPECIALIST

____
DATE