Bethanie Cooke, CPNP

Pediatric Partners of Stafford

Authorization to Release Confidential Medical Information

Patient: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Information to be Released

_____ Complete Chart _____ Shot Record _____ Last Physical

_____ Other (Please Explain) _____

The Purpose of disclosure of the above information is:

_____ Transferring to Another Pediatrician _____ Personal Use

_____ Other (Please Explain) _____

I, _____, certify the above request is accurate and hereby authorize the release of these records.
(Please Print Parent/ Guardian's Name)

From: ***Pediatric Partners of Stafford***

Address: 110 Soaring Eagle Drive
Stafford, VA 22556

Phone: (540) 720-2126

Fax: (540) 720-1002

To: _____

Address: _____

_____

Phone: _____

Fax: _____

I agree to pay all fees associated with this release.
I understand that all sections of this form must be completed before it can be processed.

Parent/ Guardian's Signature: _____ Date: _____

Office Use Only

Copying: $10.00 Administrative Fee: _____ Date Copied: _____

$0.25 Per Page: _____ Box Number: _____

Total Fee: _____ Mailed: Yes No