Pediatric Partners of Stafford

Authorization t	o Release Confidenti	al Medical Inf	ormation	
Patient:		DOB:		
Address:	· · · · · · · · · · · · · · · · · · ·	Phone:		
City:	State:		Zip Code:	
	Information to be re	leased		
Complete Chart	Sh	ot Record		Last Physical
Prior Medical Records (must	t check to be included)		Other	
The Purpose	of disclosure of the a	bove informa	tion is:	
Transferring to another Pedi	iatrician		Personal Use	
Other (Please Explain)				
	certify the above request	is accurate and h	nereby authorize the	elease of record
ease Print Parent/ Guardian's Name)				
Please Print Parent/ Guardian's Name) Please circle the TO / FR	OM appropriately to a	void delays in r		
Please Print Parent/ Guardian's Name) Please circle the TO / FR O / FROM: Pediatric Partners of Stafford	OM appropriately to a	void delays in r <i>TO / FROM:</i>	ecord processing.	
Please Print Parent/ Guardian's Name) Please circle the TO / FR O / FROM: Pediatric Partners of Stafford ddress:110 Soaring Eagle Drive Stafford, VA 22556	OM appropriately to a	void delays in r TO / FROM: Address:	ecord processing.	2.
Please Print Parent/ Guardian's Name) Please circle the TO / FR O / FROM: <i>Pediatric Partners of Stafford</i> ddress:110 Soaring Eagle Drive	OM appropriately to a	void delays in r TO / FROM: Address:	ecord processing.	2.
Please circle the TO / FR O / FROM: Pediatric Partners of Stafford address:110 Soaring Eagle Drive Stafford, VA 22556 Phone: (540) 720-2126 Fax: (540) 720-1002 agree to pay all fees associated with this release. understand that all sections of this form must be cor understand that I may revoke this authorization at an uthorization for any actions taken before receipt of v	OM appropriately to a mplete before it can be proce ny time by giving written not written notice to revoke auth	void delays in r TO / FROM: Address: Phone: Fax: essed. tice. However, I un porization. I unders	ecord processing.	revoke this
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