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

_____ Prior Medical Records (must check to be included) _____Other _____

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 records.
(Please Print Parent/ Guardian's Name)

Please circle the TO / FROM appropriately to avoid delays in record processing.

TO / FROM: ***Pediatric Partners of Stafford***

Address: 110 Soaring Eagle Drive
Stafford, VA 22556

Phone: (540) 720-2126

Fax: (540) 720-1002

TO / FROM: _____

Address: _____

_____

Phone: _____

Fax: _____

I agree to pay all fees associated with this release.
I understand that all sections of this form must be complete before it can be processed.
I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of written notice to revoke authorization. I understand that when this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by recipient and may no longer be protected.

Parent/ Guardian's Signature: _____ Date: _____

This Authorization expires 12 months from the submission date. **Please allow 7-14 business days to process Records Request.**

Office Use Only

Copying: $10.00 Administrative Fee: _____
$0.25 per Page: _____
Total Fee: _____

Date Copied: _____
Box Number: _____
Mailed: Yes No