



Pediatric Partners of Virginia

Request to Release Protected Health Information

Please complete ONE form per child

Patient Name: _____ **Date of Birth:** _____

Patient Street Address: _____ **Account /Chart:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below, provided the information has not been released.

I authorize:

to release to:

Provider's Name to release to

New Provider, Specialist, or Person Receiving Copy

Street Address

Street Address

City, State, ZIP

City, State, ZIP

Phone#

Phone # or email

For Patient or Legal Guardian Copy Requests: Paper and/or Electronic

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies, electronic devices, labor, and postage.

Information to be Released/Requested:

- ALL Records – this includes financials
- Medical Records – EMR ONLY (no financials)
- Immunizations ONLY

Labs ONLY dates: _____

Other: _____

Information to be Excluded (Not Released):

- Mental Health Records
- Drug/Alcohol Treatment
- HIV Testing

Sexual Assault/Victimization Records

Other: _____

Reason for Record Release:

- Personal copy
- Over age 18
- Change of insurance
- Referral to a specialist
- Moving out of state
- Leaving Practice

Unhappy due to office wait time

Unhappy due to customer service

Unhappy with provider

Unhappy with Practice

I have the right to refuse to sign this Authorization, and treatment, payment, enrollment, or eligibility for benefits are not conditioned on whether I sign this Authorization. This Authorization will expire two (2) years after the date of my signature, but I may revoke this Authorization for any further disclosures at any time in writing. Once the information is disclosed, it may be re-disclosed by the recipient of the information and such re-disclosure may no longer be protected by federal or state privacy laws. By my signature below, I knowingly and voluntarily authorize the use and disclosure of the information for the purposes described above:

Signature of Parent/Guardian

Printed Name

Date

**Please allow up to 30 days for processing*