# 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:**

_____
Provider's Name to release to

_____
Street Address

_____
City, State, ZIP

_____
Phone#

**to release to:**

_____
New Provider, Specialist, or Person Receiving Copy

_____
Street Address

_____
City, State, ZIP

_____
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:

| Authorized Signature | Printed Name | Date |
|---|---|---|

**Please allow up to 30 days for processing*

Revised 10/2024