PL PEDIATRICS, PLLC
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Phone (540) 361-1800
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Authorization for Release of Medical Information

Patient's Name: DOB:
Address:
City/State/Zip Code:
Phone:
Date of Request:

☐ I authorize PL Pediatrics, PLLC to relase information to:	OR	☐ I authorize PL Pediatrics, PLLC to obtain information from:
Name of Provider or Practice		Name of Provider or Practice
Address		Address
City/State/Zip		City/State/Zip
Phone & Fax		Phone & Fax

Purpose for request (check one):

☐ Transfer of care ☐ Insurance Coverage ☐ Other

Type of Records Requested (check one):

☐ Immunization history

☐ All medical records related to a specific injury or illness (list below):

☐ Treatment summary (Includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Specific information (list below):

☐ **Copy of entire medical record, as allowed by law.**

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release P.L. Pediatrics, PLLC. from, and covenant not to sue P.L. Pediatrics, PLLC. for any claim that I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy information used/disclosed under this authorization. I understand that I may revoke this consent to release information at anytime, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire six months after the date specdified below, or on the date, event or condition described as:

Virginia law allows for copy charges consititing of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.

Parent/ Guardian Signature:

Relationship to Patient: Date:

Witness Signature: Date: