Medical Records Release

Roanoke Pediatrics PLLC
1901 Denniston Ave. SW
Roanoke, VA 24015
Phone: 540-613-8565
Fax: 540-675-4001

Patient Name_____ DOB: _____
MRN: _____ Home address: _____
City: _____ State: _____ Zip: _____

I hereby authorize records from:
Name: _____
Fax: _____
For the Purpose of: Medical treatment

To be released to:
Roanoke Pediatrics PLLC
(P): 540-613-8565
(F): 540-675-4001

Information to be released:
Date Range: _____ to _____

- ☐ H&P and Discharge summary
- ☐ Most recent office note
- ☐ Lab/path results
- ☐ Immunization record
- ☐ Growth Chart
- ☐ Operative or procedure note
- ☐ Radiology reports
- ☐ Other _____

I understand that disclosure of health information is voluntary. I understand that my or my child's health information may contain information relating to sexually transmissible infections such as HIV/AIDS, behavioral or mental health services, substance use or abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written revocation to Roanoke Pediatrics PLLC. I understand that my right to revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to release related to insurance and billing purposes when the law provides my insurer the right to contest a claim under my policy.

This medical records release authorization will expire 1 year after signing date unless otherwise stated.

Patient: _____ Date: _____
Parent/Legal Guardian: _____ Time: _____
Relationship to Patient: _____
Signature of Parent/Guardian: _____