P.L. Pediatrics, PLLC – 4552 Empire Court – Fredericksburg, VA 22408
Phone: 540-371-4488

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Purpose of this Release: Physician Retirement / Medical Practice Closure

Information to be Released: Entire Medical Record

Patient Last Name	Patient First Name	Patient Date of Birth

I, _____, as an authorized representative of the above listed patient(s), authorize P.L Pediatrics, PLLC to release the healthcare information (medical records) to:

Name of Authorized Representative: _____

Relationship to the Patient(s):_____

Contact Phone Number of Authorized Representative:__(_____)_____

I am requesting the medical records in the following format (select one):

☐ Electronic ☐ Paper

By signing this Authorization for Release of Patient Health Information, I understand and agree that:

- Per Virginia Regulations, the preparation of the requested medical records may take up to 30 days from the date of this request is received to be filled and available for pick-up. Once ready, you will be contacted via the contact telephone number provided on this authorization.
- There is an administrative/copying fee of **$25.00** per patient medical record which I hereby agree to pay at the time of picking up the medical record(s). I also understand that I will need to provide valid photo identification at the time of picking up the medical record(s).
- Once I have received the copy of the medical record(s)requested by this authorization, I understand that I will have transferred the patient's care and that the practice is closing and will no longer be providing medical care to the patient(s)

Signature of Authorized Representative:_____ Date:_____

I have receive the above listed medical records:

Signature of Authorized Representative _____ Date:_____

For Office Use Only				
Date Auth. Received	Filled	Contacted	Fee Paid	Picked-Up