RICA
PEDIATRICS

WELCOME TO RICA Pediatrics!!

Childrens Information- Please list all children to be registered under this account.

Legal Last Name:	Legal First Name:	Middle Int.	Nick Name:	DOB:	Sex:
1.					☐ M ☐ F
2.					☐ M ☐ F
3.					☐ M ☐ F
4.					☐ M ☐ F
5.					☐ M ☐ F

Address: _____
City, State, Zip: _____
Primary Email: _____ Primary Phone Number: _____

Preferred Pharmacy/Location: _____ Phone #: _____

Parent/Guardian Name: _____ DOB: _____
Mobile Number: _____ Work Phone: _____
Home Address (if different from child): _____
☐ Father ☐ Mother ☐ Other City, State, Zip: _____ List as Guarantor? ☐ YES ☐ NO

Parent/Guardian Name: _____ DOB: _____
Mobile Number: _____ Work Phone: _____
Home Address (if different from child): _____
☐ Father ☐ Mother ☐ Other City, State, Zip: _____ List as Guarantor? ☐ YES ☐ NO

Alternate/Emergency Contact: _____
Phone #: _____ Relationship to Patient(s): _____

INSURANCE INFORMATION- YOU MUST HAVE YOUR INSURANCE CARD AT THE TIME OF VISIT

Primary Insurance:
Name: _____ Member ID#: _____
Group #: _____ Policy Holder: _____
Policy Holder DOB: _____ SSN: _____

Secondary Insurance:
Name: _____ Member ID#: _____
Group #: _____ Policy Holder: _____
Policy Holder DOB: _____ SSN: _____

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

I understand that I am financially responsible for all professional charges that my children may incur. All copayments and non-covered charges are due at the time of service. All costs not paid by insurance are due upon receipt of the statement.
I hereby authorize the payment of medical benefits directly to Pediatric Partners of Virginia. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations. Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to treat my child in their office as required by the events of an emergency. Acknowledgment of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for RICA Pediatrics.

Signature: _____ Name: _____ Date: _____

RICA Pediatrics Consent for Treatment

I understand that the laws of Virginia require that if my physician or any person employed by my physician(s) is directly exposed to my child's bodily fluids that may transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses according to the current guidelines for the Center of Disease Control (CDC), that I consent to have my child tested for infection with HIV or Hepatitis B or C viruses.

I further understand that by law, I consent to the release of these test results to the person(s) who are exposed to my child's bodily fluids. I further give my permission for RICA Pediatrics to treat my child(ren), _____ _____, according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

Signature: _____ Date:_____

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (i.e. Nanny, Grandparent, Stepparent, and/or teen by themselves)

I, _____, do hereby consent to RICA Pediatric and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments. I give the Provider and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for verbal consent if the treatment plan includes vaccines, and the best number to reach me for this is _____.

Signature: _____ Date: _____

OPTIONAL: DISCLOSURES TO FAMILY / FRIENDS (not including daycare, schools, camps)

Please list all persons (Grandparent, babysitter, friend, etc.) who may receive health information regarding my child(ren), such as but not limited to scheduling, medical advice, treatment, prescriptions, medical forms, medical records, and billing information. These individuals may be asked to present identification. If someone other than those you listed below contacts us regarding your child, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to contact you.

NAME, RELATIONSHIP, PHONE Number, Restrictions (if any)

_____

_____

This authorization will remain in effect until further written notice by the patient/legal representative to discontinue. I understand that once information is released, it may be subject to redisclosure by the party receiving it and may no longer be protected by federal or state law.

Signature: _____Name: _____ Date: _____

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD

RICA
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Office Procedure and Financial Policy

Thank you for choosing us as your pediatric office. The goal of the Provider and staff of RICA Pediatrics is to provide the best possible medical care for you and to develop and maintain a relationship with you that will grow and strengthen through the years ahead. Along with our medical relationship, we will be establishing a financial relationship. In order to successfully maintain this relationship, we want you to have a clear understanding of our financial policy. We ask that you read, understand and sign this policy statement **prior to any treatment.**

Insurance Verification

It is your responsibility to verify with your insurance carrier prior to your appointment that our physicians are participating providers with your specific plan. As a patient, you are responsible for **thoroughly understanding** your insurance benefits. This includes what items your insurance will or will not cover and **any special facilities that need to be utilized for labs and x-ray services** that the doctor might order for you. This is important as **RICA Pediatrics cannot be responsible for services provided at non-contracted facilities.** As a courtesy to our insurance patients, we will bill both primary and secondary medical insurance. However, in order for us to bill for an appointment, you must submit **proof of current insurance coverage** at the time of the visit. **Without current proof of coverage, payment for the services will be required at the time the service is rendered.** If insurance information is submitted after the date of service, we will be glad to bill your insurance and refund your payment.

Payment for Services

RICA Pediatrics instituted a **mandatory** financial requirement for all of our patients. Please read the attached Payment for Services sheet, complete and sign the Credit Card Authorization form and return to our office before leaving the office today.

Cancellation Policy

A specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, **we require you give us a 48 hours notice** that we may reschedule your appointment and offer the reserved time to another patient. It is our policy to charge **$35.00** for appointments that have been scheduled in advance and are cancelled with less than 48 hours' notice (**this includes same day appointments**). **The charge will be the same as the scheduled appointment and is not covered by insurance.**

Additional Health Issues Addressed During Preventative Care Appointments.

Preventative Care is an important part of your good health. We recommend and follow the schedule established by the American Academy of Pediatrics. Unfortunately, through the years, insurance companies have continued to limit the scope of issues that they will cover during these preventative care exams. Sometimes during these exams, the physician will diagnose and treat another health problem. **Services for the other problem will be billed as a separate office visit along with your well care visit.** Please be aware that some insurance companies may require that patients pay separate co-pay for this office visit. If you have extra issues to discuss, please inform the staff so that they can schedule additional time for your concerns.

Telephone Consultations

There may be a consultation charge for complex or lengthy telephone calls with the doctor to discuss your health problems. We will be glad to bill your insurance company, however, if these charges are not covered under your health plan, you will be responsible for the payment.

Completion of Forms and Request for Medical Records

If you have letters or forms for our doctors to complete, (camp, school, etc.), please be aware that there is an administration fee per form for turnaround in 5 – 7 business days. If forms are needed sooner, there will be an additional charge. There is also a fee for duplication of medical records per patient if records are to be picked up. An additional fee will be charged if the chart is exceptionally large or if you request that the records be mailed. Please be advised that we do not fax medical records.

Maintaining a Respectful Environment

The doctors and staff strive to treat our patients and their parents with courtesy and respect.
It is also important that we insure that our staff is treated with respect from our patients as well.
We feel very strongly that our staff should be able to work in an environment free from verbal and physical abuse. **Angry outbursts against our staff will not be tolerated and may result in your discharge from the practice.**

I have read and understand the financial policies of RICA Pediatrics.

Patient's Signature _____ Date _____

RICA Pediatrics
Patient Rights and Responsibilities

You have the right to:

- Be treated with courtesy and respect, with an appreciation of your dignity, and with protection of your need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what patient support services are available, including whether an interpreter is available if you do not speak English.
- Bring any person of your choosing to the patient-accessible areas of your RICA Pediatrics clinic to accompany you while you are receiving care or consulting with your clinician unless doing so would risk the safety or health of yourself, other patients or the office staff or cannot be reasonably accommodated by the office or provider.
- Know what rules and regulations apply to your conduct.
- Be given information concerning diagnosis, evaluation, planned course of treatment, alternatives, risks, and prognosis.
- When it is medically inadvisable for you to receive such information, the information will be provided to a person designated by you or to a legally authorized person.
- Participate in decisions involving your healthcare, except when such participation is contraindicated for medical reasons.
- Refuse any treatment except otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- Receive a reasonable estimate of charges for medical care upon request and prior to treatment.
- Receive a copy of a reasonably clear and understandable itemized bill and have the charges explained upon request.
- Impartial access to medical treatment or accommodations regardless of race, national origin, religion, handicap or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and give your consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of your rights, as stated by Virginia law, through the RICA Pediatrics grievance procedure and to the appropriate state licensing agency.
- Change your provider if other providers are available.

YOUR RESPONSIBILITIES

You are responsible for:

- Treating all healthcare professionals, staff, and other patients with respect.
- Providing RICA Pediatrics with accurate and complete information to the best of your knowledge about present complaints, past illnesses, hospitalizations, medications including over-the-counter products, dietary supplements, any allergies and sensitivities, or other matters relating to your health.
- Reporting unexpected changes in your condition to RICA Pediatrics.
- Reporting whether you comprehend a contemplated course of action and what is expected of you to the provider.
- Following the treatment plan recommended by RICA Pediatrics and to participate in your care.
- Keep appointments and notify RICA Pediatrics clinic when you're unable to do so for any reason.
- Your actions, should you refuse treatment or do not follow RICA Pediatrics instructions.
- Assuring the financial obligations of your healthcare are fulfilled as promptly as possible, including any charges not covered by insurance.
- Following healthcare facility rules and regulations affecting patient care and conduct.

COMPLAINTS & GRIEVANCES

If you experienced a problem that was not resolved to your satisfaction, you may file a complaint or grievance with the office manager in your provider's office location. All complaints and grievances are handled equally, and action will be taken to resolve them right away. You may also file a complaint or grievance either in writing or by calling:

RICA Pediatrics Manager at (703) 232-1122 or kidz@ricapediatrics.com ATTN: Management (in the subject line).

Initials:

Revised 09/2025

RICA
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CASH PAY POLICY

Today's Date: _____

Patients without medical insurance are required to pay a deposit of $150 dollars at the time of service to see a primary care provider. **Please note** that your balance may be more than the deposit amount and will be determined by the actual services rendered during your visit. Laboratory testing charges will be billed separately. Any patient without medical insurance who is paying with cash for an office visit will receive 10% off their final balance.

By signing below, you state that you have read and understand this Cash Pay Policy.

Patient/Guardian Signature: _____ **Date:** _____

Attention Patients who are out-of-network or have NO insurance: The No Surprises Act was enacted on January 1, 2022, to provide additional billing rights and protection to self-pay patients and those using insurance with an out-of-network plan. Under this law, healthcare providers must provide patients who are using out-of-network insurance or who have no insurance with an estimate of what their visit to the facility may cost. This statement is called a "Good Faith Estimate (GFE)."

Important:

•The law protects patients against "Surprise" balancing billing.

•As a patient using out-of-network insurance, or paying out-of-pocket, you have the right to receive a GFE. A GFE is an estimate of the total expected charges of the patient's visit and does not reflect other services requested and added by the patient at the time of service.

•Any bill received which is "Substantially in excess" ($400 or more) of the total expected charges listed on the GFE can be disputed. Please contact RICA Pediatric if you wish to begin the dispute process at (703) 232-1122 or ATTN: Billing in the subject line to kidz@ricapediatrics.com.

Does this apply to you? Unsure if it does? Find out!

Please inform the front desk if you are using out-of-network insurance or if you do not have insurance. You can find out about our network status with your insurance plan by contacting the insurance company directly using the number on the back of your insurance card. If you have questions about this process, please contact the office at (703) 232-1122.

If you have questions or would like more information about the No Surprises Act, please visit www.cms.gov/nosuprises or call 1-800-985-3059

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting the Virginia Center for Allergy & Asthma at the office numbers above.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Virginia and will be in Virginia during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature	Date

RICA Pediatrics
Carla Lalota, MSN FNP-C
282 Choptank Rd STE 103
Stafford, VA 22554
Phone Number: (703) 232-1122
Fax Number: (571) 316-1387

Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination.

Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of four, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> "In *1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen.*"

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chicken pox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of under immunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 2,000 cases of whooping coughs in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness had made a conscious decision not to vaccinate. Furthermore, by

Adapted from All Star Pediatrics, Exton, Pennsylvania

Immunize.org

****Please sign and date on the back of this form*****

continued the next page

Not vaccinating your child, you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with your healthcare provider in advance of your visit. In some cases, we may alter the schedule to accommodate parental concerns or reservations.

Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at *[Your practice name here]*. Such additional visits will require additional co-pays on your part. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

All patients in the practice are strongly encouraged to receive hepatitis B vaccine at birth, DTaP, Hib, polio, pneumococcal, and rotavirus vaccines by three months of age; measles, mumps and rubella, varicella (chickenpox), and hepatitis A vaccines at age 12–15 months; HPV and meningococcal vaccine at 11–12 years (HPV can also be given as early as 9 years); and annual influenza and COVID-19 vaccine. Also, if RSV vaccine was not given during pregnancy, your newborn should receive an RSV preventive antibody before or during the RSV season. You can view a parent-friendly version of this schedule at www.immunize.org/catg.d/p4050.pdf.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

All the healthcare providers of RICA PEDIATRICS -
CARLA LALOTA, FNP-C

I acknowledge that I have read this document in its entirety and understand it. You may download a sample of this letter by scanning the QR code on the first page.

Parent / Guardian Signature: _____ **Date:** _____

Refusal of Recommended Immunizations

Child's Name _____ ID# _____ DOB _____

Parent's / Guardian's Name _____

My child's pediatrician or other health care provider, _____, has advised me that my child (named above) should receive each vaccine or immunization checked below:

Recommended today, *which prevents these serious complications:*	**Today I refused:** *Initials of Parent or Guardian*
☐ **COVID-19 vaccine** *Pneumonia, respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death*	
☐ **Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine** *Tetanus – broken bones, breathing difficulty, death; Diphtheria – swelling of the heart muscle, heart failure, coma, paralysis, death; Pertussis(whooping cough) – pneumonia, death*	
☐ **Haemophilus *influenzae* type B (Hib) vaccine** *Meningitis, intellectual disability, closing of the throat, pneumonia, death*	
☐ **Hepatitis A (HepA) vaccine** *Liver failure, joint pain, kidney, pancreatic and blood disorders, death*	
☐ **Hepatitis B (HepB) vaccine** *Chronic liver infection, liver failure, liver cancer, death*	
☐ **Human papillomavirus (HPV) vaccine** *Cervical, vaginal, vulvar, penile, anal, mouth and throat cancers*	
☐ **Influenza (flu) vaccine** *Pneumonia, bronchitis, sinus infections, ear infections, death*	
☐ **Measles, mumps, and rubella (MMR) vaccine** *Measles - brain swelling, pneumonia, death; Mumps - meningitis, brain swelling, swelling of testicles or ovaries, deafness, death; Rubella – miscarriage, stillbirth, premature delivery, birth defects*	
☐ **Meningococcal (circle: MenACWY / MenB / MenABCWY) vaccine** *Meningitis, infection of the bloodstream, blindness, deafness, loss of limbs, death*	
☐ **Pneumococcal (PCV) vaccine** *Blood infection, meningitis, death*	
☐ **Poliovirus (IPV) vaccine (inactivated)** *Paralysis, death*	
☐ **Respiratory syncytial virus (RSV) immunization** *Bronchiolitis, pneumonia, lung failure, death*	
☐ **Rotavirus (RV) vaccine** *Severe diarrhea, dehydration, death*	
☐ **Varicella Chickenpox (VAR) vaccine** *Infected blisters, bleeding disorders, brain swelling, pneumonia, death*	
☐ **Others (please list)** _____	

I have been given a Vaccine Information Statement from the Centers for Disease Control and Prevention that explains each immunization and the disease(s) it prevents. I have discussed the recommendation and my refusal with my child's pediatrician or other healthcare provider. They have answered all of my questions about the recommended immunizations. I know I can find more information at https://www.cdc.gov/vaccines/parents/FAQs.html.

I understand the following:

- The checked immunization(s) are recommended by my child's pediatrician or healthcare provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention.
- The benefits and risks of the recommended immunization(s) checked.
- If my child does not receive the immunization(s) according to the standard, evidence-based schedule, the consequences may include:
  - Contracting the illness the immunization is designed to prevent, which could lead to serious complications as listed in the table.
  - Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.
- Some immunization-preventable diseases are common in other countries. My unvaccinated child could get one of these diseases while traveling or from someone who traveled to another country.

Today, I refused the recommended immunization(s) for my child by initialing the box(es) in the column titled "Today I refused."

I agree to tell all health care professionals in all settings which immunization(s) my child has not received and if my child is under immunized, as my child may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been immunized.

If you change your mind at any time, speak with your child's pediatrician or other health care provider. You can always accept immunization(s) for your child in the future.

I acknowledge that I have read this document in its entirety and understand it.

Parent / Guardian Signature: _____ Date: _____

Pediatrician / Other Health Care Provider: _____ Date: _____

 If your practice requires modifications, please use the Refusal to Vaccinate template.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth(s): _____

Address: _____

City, State, and zip code: _____

RECORDS REQUESTED FROM:

Name of Person or Facility: _____

Practice Address: _____

City, State, and Zip Code: _____

Phone_____ Fax: _____

RECORDS TO USE OR DISCLOSE TO:

Name of Person or Facility: RICA PEDIATRICS

Practice Address: 282 CHOPTANK RD STE 103

City, State, and Zip Code: STAFFORD, VA 22556

Phone and Fax: 703-232-1122 F: 571-316-1387

I, _____ certify the above request is accurate and hereby authorize the release of records.

Please select all the specific documents that apply to your request:

☐ Complete Chart	☐ Immunization Records	☐ Last Physical	☐ Prior Medical Records
☐ **Other:**			

Please select the purpose of your request:

☐ Continued patient care	☐ Attorney/Legal	☐ Insurance	☐ Social Service/ Disability
☐ Personal	☐ **Other**		

I agree to pay all fees associated with this release.

I understand that all sections of this form must be complete before it can be processed.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of written notice to revoke authorization. I understand that when this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by recipient and may no longer be protected.

Parent/Guardian Signature: _____ Date: _____

This Authorization expires 12 months from submission date. Please allow 7-14 business days to process records request.

Office Use Only

Hard Copy: $25.00 Administration fee Date Copied: _____ Mailed: ☐ YES ☐ NO