Authorization for Medical Information Release

FLAT ROCK PEDIATRICS
a division of ppv

_____ Patient's Full Legal Name

_____ Patient's Date of Birth

_____ Street Address

_____ Primary Phone Number

_____ City, State, Zip Code

_____ Secondary Phone Number

I, _____, do hereby authorize the release of:
Patient or Legal Representative

_____ Discharge Summary	_____ Pathology Reports	_____ Emergency Reports
_____ History and Physical	_____ Laboratory Reports	_____ Hospital Reports
_____ Progress Notes	_____ Radiology Reports	_____ Immunization Records
_____ Operative Notes	_____ ECG/EEG/Cardiac Cath	_____ ALL OF THE ABOVE

___ I Do **or** ___ I Do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) and/or HIV (Human Immunodeficiency Virus), psychiatric care and/or psychological assessments, and treatment for alcohol and/or drug abuse.

Please release my information ___ to **or** ___ from:
Practice Name: _____
Practice Address: _____
_____
Practice Phone: _____
Practice Fax: _____

Please release my information ___ from or ___ to:
Flat Rock Pediatrics
1583 Standing Ridge Dr, Suite E, Powhatan, VA, 23139
Phone: (804) 375-1589
Fax: (804) 325-1190

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to redisclosure by the person, class of persons, or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition the treatment of the patient on whether or not his authorization is signed.

_____ Signature

_____ Name (Print)

_____ Date