210 N. 21st Street, Suite A
Purcellville, VA 20132
Phone: 540-338-3320
Fax: 540-338-2280
www.purcellvillepediatrics.com

Consent for Release of Information Form

I, _____, give my permission for
(parent/guardian)

_____
(sending professional/agency name)

_____
(sending professional/agency address)

_____
(sending professional/agency phone number)

_____
(sending professional/agency fax number)

to release my childs medical records to Purcellville Pediatrics, PLLC. This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time.

This information will be used to plan and coordinate the care of:

Name of Child: _____ Date of Birth: _____

Name of Child: _____ Date of Birth: _____

Parent/Guardian Name: _____
(print full name)

Parent/Guardian Signature: _____ Date: _____

Parents or Guardians signing this document have a legal right to receive a copy of this authorization.

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Virginia laws, all personal and health information is private and must be protected.