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Manassas, VA 20109
P: (703) 361-7131 Fax: (703) 330-2065

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Gainesville, VA 20155
P: (703) 753-6184 Fax: (703) 753-2988

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Regulations.

Patient Name: _____ **Account:** _____

Date of Birth: _____

Release Information From: _____

_____

Release Information To: _____

_____

Purpose of Use: _____

_____

Information to be Released:
{ } Medical Records { } Labs { } Consults { } Psychiatric Information { } Shot Record

****If medical records are being faxed, PLEASE DO NOT FAX over 15 pages.****

I understand that my records are protected under Federal and State confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in laws and regulations. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. As a professional courtesy, there is no charge if transferring active patient records to a new physician's office. I understand that I will be charged a $15.00 copy fee per disc if records are picked up at Crestwood Pediatric. There will be a fee of $0.50 per page up to 50 pages and $0.25 per page thereafter fifty pages for paper records.

I understand that this authorization will expire on the following date: _____

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____ Date: _____