Pedsplus Primary Care

2565 Cowan Blvd, Fredericksburg, VA
Tel. 540-289-2273 Fax. 888-801-8599

Patient Authorization for Release of Medical Information

PATIENT INFORMATION

Name_____ Birth Date: _____

Address: _____ Phone _____

City_____ State _____ Zip _____

RELEASE INFORMATION FROM: _____

Address_____

TEL. _____FAX: _____

RELEASE INFORMATION TO: _____

Address: _____

Tel. _____Fax: _____

DESCRIPTION OF INFORMATION BEING RELEASED

___All Medical Records (Note, Labs, Reports, x-rays, CDs)

___Specific Items only (Please specify)_____

SENSITIVE INFORMATION RELEASE:

I hereby authorize PEDSPLUS PRIMARY CARE to use or disclose protected health information regarding my child's care and treatment.
I understand I have the right to revoke this authorization at any time. I understand that if I revoked this authorization, I must do so in writing and present my writing requestto Pedsplus Primary Care. I understand that the revocation will not applied to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under the federal privacy laws or regulations. I understand Pedsplus Primary Care will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allow by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to a copy of this authorization.
This authorization will expire 1 year from the date of signature, unless revoked by patient, legal guardian, power of attorney, or healthcare surrogate.

Parent/Guardian_____Relationshiop to Patient_____

Signature: _____Date_____/_____/_____

1st Attempt_____ 2nd Attempt_____ 3rd/final Attempt_____