Pediatric Associates of Charlottesville, PLC
Patient Authorization for Another Health Professional to Release
Protected Health Information to Pediatric Associates of Charlottesville

Patient(s)	Name(s) DOB
Who has the medical records you would like released?	Name of Physician/Third Party Name of Practice/Hospital Telephone Number Fax Number Address City State Zip
Where should the information be sent?	Pediatric Associates of Charlottesville, PLC 1011 East Jefferson Street Charlottesville, VA 22902 Telephone: (434) 296-9161 Fax:(434)977-6068
Information to be disclosed?	___All (including records related to mental health, HIV, alcohol or drug abuse) ___All (except records related to mental health) ___Office notes ___Diagnostic tests ___Immunization Record ___Lab reports ___Radiology reports ___Other:_____ Dates of Service:_____
Reason for Disclosure?	___Insurance change ___Moving out of area ___Leaving practice ___Referral to specialist ___Court/Custody case ___Second opinion ___Other:_____
Revocation	I understand that this authorization will be in effect for 12 months unless canceled by me in writing, and that my cancellation will take effect when the provider receives my notice in writing.
Authorization	I hereby release and authorize the location listed above to release the medical records of the dependent(s) listed above (or self if 18 years or older) to Pediatric Associates of Charlottesville, PLC. I hereby state that I am the parent or court appointed legal guardian and have the legal right to make or retract healthcare decisions regarding the patient(s) listed above, and that my parental authority has not been terminated or restricted by the courts. Patient/Parent/Legal Guardian's signature_____ Date:_____ Name of signee:_____ Relationship to patient:_____