**Pediatric Associates of Charlottesville, PLC**
**Patient Authorization for Pediatric Associates of Charlottesville to Release Protected Health Information to Other Physicians/Third Parties**

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| Patient(s) | Name(s) DOB |
| Where should the information be sent? | Name of Physician/Third Party Name of Practice/Hospital<br>Telephone Number Fax Number<br>Address<br>City State Zip |
| Who has the medical records you would like released? | Pediatric Associates of Charlottesville<br>1011 East Jefferson Street<br>Charlottesville, VA 22902<br>Telephone: (434) 296-9161 Fax:(434)977-6068 |
| Information to be disclosed? | ___All (including records related to mental health, HIV, alcohol or drug abuse)<br>___All (except records related to mental health)<br>___Office notes ___Diagnostic tests ___Immunization Record<br>___Lab reports ___Radiology reports<br>___Other:_____<br>___Dates of Service:_____ |
| Reason for disclosure? | ___Insurance change ___Moving out of area ___Leaving practice<br>___Referral to specialist ___Court/Custody case ___Second opinion<br>___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 Pediatric Associates of Charlottesville, PLC to release the medical records of the dependent(s) listed above (or self if 18 years or older) to the location listed above. 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.<br>Patient/Parent/Legal Guardian's signature_____ Date:_____<br>Name of signee:_____ Relationship to patient:_____ |