

Pediatric Associates of Charlottesville, PLC

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

Patient	Name	DOB
Who has the medical records you would like released?	Name of Physicians / Third Party Telephone Number Address City	Name of Practice / Hospital Fax Number State Zip
Where should the information be sent?	Pediatric Associates of Charlottesville 1011 East Jefferson Street Charlottesville, VA 22902 Telephone: (434) 296-9161 Fax: (434) 977-6068	
Information to be disclosed?	<input type="checkbox"/> All (including records related to mental health, HIV, alcohol or drug abuse) <input type="checkbox"/> All (except records related to mental health) <input type="checkbox"/> Office notes <input type="checkbox"/> Diagnostic test <input type="checkbox"/> Immunization Record <input type="checkbox"/> Lab reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Communication <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dates of Service: _____	
Reason for disclosure?	<input type="checkbox"/> Insurance change <input type="checkbox"/> Moving out of area <input type="checkbox"/> Leaving practice <input type="checkbox"/> Referral to specialist <input type="checkbox"/> Court / custody case <input type="checkbox"/> Second opinion <input type="checkbox"/> Other: _____	
Revocation	I understand that this authorization will be in effect for 12 months unless canceled by me in writing, and that my cancelation 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. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Patient / Parent / Legal Guardian's signature _____ Date: _____ Name of signee: _____ Relationship to Patient: _____ <i>The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent, or as otherwise permitted by 42 CFR Part 2.</i>	