Request that Medical Records from Another Healthcare Provider be sent to Piedmont Pediatrics

PLEASE PRINT CLEARLY, otherwise your request may be revoked or delayed

For the patient(s) identified in the list below, I, _____ of
Name

_____ authorize
Address and Phone Number

Name of Healthcare Provider or Facility: _____

Complete Address: _____

_____

Phone and Fax: _____

to release the standard set of medical records (immunization record, growth chart(s), problem list, most recent well visit physical exam, consultant notes and other information important to the patient's ongoing care) to:

Piedmont Pediatrics
900 Rio East Court, Suite A **(434) 975-7777**
Charlottesville, VA 22901 **(434) 975-7774 Fax**

Patient Name	Date of Birth	Social Security	Dates of Service
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

Purpose of Request: ☐ **Personal Use** ☐ **Transfer of Care** ☐ Other: _____

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include, if applicable, PSYCHIATRIC, DRUG/ALCOHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have to right to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or other person, or when the revocation is not permitted by law.

I agree that I am financially responsible to the provider of these records for the fees associated with my request: $0.50 per page up to 50 pages, $0.25 per page 51 pages and up, a $10 search and handling fee plus all postage and shipping costs. At the discretion of the provider of these records, fees may be waived when sent directly to another other health care provider.

If you prefer the entire record, instead of the standard record release described above, please initial: _____

Special Instructions (none if blank): _____

_____

This authorization is only valid for the information/purpose(s) indicated above and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.

X _____

Signature of Patient or Legal Representative **Date**

If signing by Legal Representative, indicate **relationship to patient**: _____