900 Rio East Court, Suite A, Charlottesville, VA 22901
(434) 975-7777 • Fax (434) 975-7774 • PiedmontPediatrics.net

Authorization for Release of Information

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

For the patient(s) identified in the list below, I, _____ authorize **Piedmont Pediatrics** to **release the standard set of medical records** (immunization record, growth chart(s), problem list, most recent well visit physical exam, and other information that my child's physician feels is important to his/her ongoing care) to:

_____

Please provide Name, Address and Phone Number

_____

Patient Name	**Date of Birth**	**Social Security Number**
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

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

If you are moving out of the area, please provide:

_____

New Address & Phone Number ***Date of Move***

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 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. Fees may be waived for your first copy or when sent directly to other health care providers or agencies.

If you prefer the entire record, instead of our 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**: _____

For office staff, date or initial each item as completed:

Request rcvd:	Is patient < 18 yrs if legal rep signing? Y N	Review completed by: on:
Is form complete? Y N	Rvwd billing acct status? Y N	Records sent by: on: via:
Legal rep on file? Y N	Records printed by: on:	If transfer of care, patient marked inactive by: