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Manassas, VA 20109
P: (703) 361-7131 Fax: (703) 330-2065

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Gainesville, VA 20155
P: (703) 753-6184 Fax: (703) 753-2988

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Regulations.

Patient Name: ____ **Account:** ____________________

Date of Birth: ______________________

Release Information From: ____

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Release Information To: ____

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Purpose of Use: ____

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Information to be Released:
{ } Medical Records { } Labs { } Consults { } Psychiatric Information { } Shot Record

I understand that my records are protected under Federal and State confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in laws and regulations. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. As a professional courtesy, there is no charge if transferring active patient records to a new physician's office. I understand that I will be charged a $15.00 copy fee if records are picked up at Crestwood Pediatric. There will be an additional $20.00 fee if patient records have to be retrieved from storage.

I understand that this authorization will expire on the following date: ______________________

Signature of Parent or Guardian: ________________________________ Date: _____________

Printed Name of Parent or Guardian: _____________________________ Date: _____________