
*Northern Virginia Internal Medicine & Pediatrics, P.C.*

SPECIALIST FOR ADULTS. SPECIALIST FOR KIDS.
CARE FOR THE ENTIRE FAMILY.
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## Authorization to Release Medical Records

**Date:** _____

**Patient Name:** _____

**Date of Birth:** _____

**Address:** _____

_____

**Phone Number:** _____

**I hereby authorize Northern Virginia Internal Medicine and Pediatrics to use, release and/or disclose a copy of my medical records and protected health information to:**

**[ ] Mail to Patient's Address**
**[ ] Mail to Doctor's Address (enter name and address):**

_____

_____

_____

_____

**Purpose of Release and/or Disclosure:**

_____

- I understand that I may revoke/cancel this authorization at any time by giving written notice of my decision to do so.
- I understand that once my records are released that they will no longer be within your control and could potentially be re-released or re-disclosed by the recipient.
- I understand there may be a cost for photocopying, handling and mailing of my records
- This authorization will expire 90 days from the date on this form after which it will no longer be valid

**Patient Signature (if over 18):** _____
**Parent/Guardian Signature (if patient under 18):** _____
**Relationship to Patient:** _____