PEDIATRIC AND
ADOLESCENT CARE

7500 Iron Bar Lane, Suite 120
Gainesville, VA 20155
Phone: 703-753-6772 (MSPA)
Fax: (888) 972-4515
www.milestoneskids.com

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

REGARDING PATIENT: ________________________________ DATE OF BIRTH________________________

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Your previous Doctor's office : ____

Your previous Doctor's *Fax #:* _________________________ *Phone #:* _________________________

To whom it may concern:

I hereby request that a copy of my child's medical records (growth chart, immunizations record and only the most recent well child exam) be released and forwarded to Milestones Pediatric and Adolescent Care, fax number **888-972-4515** or mailed to:

Milestones Pediatric and Adolescent Care
7500 Iron Bar Lane, Suite 120
Gainesville, VA 20155

Please include a copy of all pertinent laboratory and X-ray findings. Other medical records should be submitted only if pertinent to chronic issue or condition.

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records, I understand that on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Thank you for your assistance in this matter.

This authorization expires on (date) or (event):_______________________________________

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign:

____

Relationship or Authority of Legal Representative:_____________________________________

Witness:_____________________________ Date:_________________________________