RICHESON DRIVE Pediatrics

105 Richeson Drive
Lynchburg, Virginia 24501
434-385-7776 fax 434-385-5846

Release of Medical Information

AUTHORIZATION to use or disclose Protected Health Information

1. Patient Name: _____ **Date of Birth:** _____ **Date:**_____

Phone_____ **Address**_____ **ss#**_____

Relationship to patient _____signature_____

2. RELEASE FROM:	**3. RELEASE TO:**
Office Name	**Office Name:**
Address	**Address**
Phone	**phone**
Fax	**fax**

4. Information to be released

Dates of service from_____To_____

( ) OFFICE NOTES ( ) Labs/X-ray ( ) Immunization record ( ) complete chart ( ) OTHER_____

4a. Federal and State Law require special permission to release certain information. Please check if these records should be released.

( ) Mental Health ( ) Alcohol/drug abuse ( ) Hiv/Aids test results ( ) developmental disabilities

5. REASON FOR TRANSFER OF RECORDS

( )Change of insurance to:_____ ( ) Transferring care to Dr,_____

( ) Other_____

( )Relocation (new address) _____

6. EXPIRATION

This authorization will expire on _____/_____/_____. If I do not indicate a date, this will expire one year from the date of my signature below.

I authorize the use and/or release of my or my dependents protected health information as described below by Richeson Drive Pediatrics, Inc. I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this authorization by providing written notice to Richeson Drive Pediatrics, Inc. Revocation of this authorization will not affect any action taken before receipt of the written revocation.

I agree to pay any fees for copying and/or summarizing my protected health information. I agree to pay for any fees for completing forms and/or preparation of any medical reports on my behalf.

7. SIGNATURE

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in the form.

Signature_____ **Date**_____

Authorized Representative (PRINT)_____Relationship to Patient_____