

Authorization to Release Confidential Medical Information

I, _____ authorize the following office:

Name: _____
Organization: _____
Street Address: _____
City, State, Zip: _____
Fax Number: _____

to transfer the records of the following children:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

to the following physician:

**P.L. Pediatrics, PLLC.
Dr. Pamela Mancini
321 Park Hill Drive
Fredericksburg, Virginia. 22401**

Information to be Released/Obtained

- | | |
|---|---|
| <input type="checkbox"/> Complete Chart* | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Final Discharge Summary | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Emergency Room Reports | <input type="checkbox"/> HIV Records* |
| <input type="checkbox"/> Psychiatric Records* | |
| <input type="checkbox"/> Drug and Alcohol* | |
| <input type="checkbox"/> Other (please specify) _____ | |

*Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form

VA law allows for copy charges consisting of the following: \$10.00 administrative fee PLUS \$.50 per page for the first 50 pages and \$.25 per page thereafter, and \$1.00 per page of microfilm/fiche.

I hereby authorize, allow, and cause the release of information indicate above. No threat of utter coercive measures have induced me to sign this form, and I do release P.L. Pediatrics PLLC from, and covenant not to sue P.L. Pediatrics, PLLC. for any claim that i have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy of information used/disclosed under this authorization. I understand that I may revoke this consent to release information at anytime, except where actions have already been taken on the basis of this release. If i do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:

Parent/Guardian Signature: _____ Date: _____
Authority of Individual Signing for Patient: _____ Date: _____
Witness Signature: _____ Date: _____