WARRENTON & LINTON HALL PEDIATRICS, LLC

Medical Records Release Form

Authorization for the Release of Protected Health Information

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Name: _____ **DOB:** ____/____/____

Name: _____ **DOB:** ____/____/____

Name: _____ **DOB:** ____/____/____

Name: _____ **DOB:** ____/____/____

Organization Providing Information:
Warrenton Pediatrics, LLC
28 Blackwell Park Ln, Suite 103
Warrenton, VA 20186
Phone: 540-349-3225
Fax: 540-349-1204

Organization or Individual Receiving Information:
Name: _____
Address: _____
City,State,Zip: _____
Phone: _____
Fax: _____

Specific Description of the Information to be Disclosed:

❒ School Entrance Health Form ❒ Immunization Records ❒ All Records ❒ Other

_____

_____

Specific information for the following time period: From ____/____/____ to ____/____/____

Reason for Release: ❒ School ❒ Daycare ❒ Other _____
❒ Relocating __/__/__ ❒ Change Doctors
If relocating provide new address: _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. I understand that I have the right to refuse to sign this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office to the attention of the Privacy Officer. Absent such written revocation, **this *Authorization Form for Release of Protected Health Information* will expire in 2-years from the date initiated below.**

_____ _____
Signature of Parent, Patient or Guardian *Date*

_____ _____
Printed Name of Parent, Patient or Guardian *Relationship*