3708 South Main St., Suite B, Blacksburg, VA 24060
Phone: 540-739-3623 Fax: 540-408-0428
info@nbpedsva.com

Medical Records Release

- Patient Name: _____ Date of Birth: _____
  Last 4 of SSN:_____

I, _____, hereby authorize the below office/hospital and its physicians' employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug or alcohol abuse, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Hospital/office name: _____

Address: _____

_____

Phone number: _____ Fax number: _____

I, _____, hereby request and authorize the release of my child's complete medical records to be sent to the following medical practice:

New Beginnings Pediatrics

3708 South Main St, Suite B

Blacksburg, VA 24060

Phone: 540-739-3623 Fax: 540-408-0428

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Parent/Legal Guardian Name _____ Relationship to patient: _____

Parent/Legal Guardian Signature: _____ Date: _____