Medical Records Release

Please complete the following form to request records for New Beginnings Pediatrics patient records dated **prior to March 2024**. Please fax to APCA at (833) 464-3281 or mail/dropoff to 1691 Innovation Drive, Suite 2100, Blacksburg, VA 24060.

Patient Name:_____ Date of Birth:_____

I, _____ (parent/guardian), authorize New Beginnings Pediatrics/APCA to release my/my child's records to the following person, physician or organization:

Physician/Organization Name: _____
Physician/Organization Address: _____
_____
Physician/Phone Number: _____
Physician/Organization Fax Number (REQUIRED:) _____

Portion(s) of records to be released include (please check desired items to be released):

- __ **COMPLETE Medical Record**
- __ Vaccination Record Only
- __ Office Notes Only
- __ Labs/Studies Only
- __ Radiology Reports Only
- __ Sensitive Information (examples include: STD Testing, HIV testing, psychiatric records, etc)
- Other (please explain):_____ _____

This purpose of this disclosure is:

- __ Personal Records
- __ Continuity of Care
- __ Transfer of Care
- __ Other: (please explain) _____
- __ Insurance Processing
- __ Legal

I understand that my records are confidential and may be disclosed only as authorized in this consent or as required by law. I also understand that this is revocable by me at any time except that action has been taken in reliance on this consent. Unless otherwise specified below, this consent will automatically expire after one year from the date above.

Signature: _____ Date: _____
Relationship to patient: _____ Request consent to expire: _____

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