New Beginnings PEDIATRICS
3708 South Main Street, Suite B
Blacksburg VA, 24060
Phone: 540-739-3623 • Fax: 540-739-3979

Obtain Medical Records

Patient Name:_____ Last four of SSN: _____
Date of Birth:_____

I authorize and request Dr. _____ (Fax) _____ to release my records to New Beginnings Pediatrics. Please fax to 540-739-3979. For questions, you may call New Beginnings Pediatrics at 540-739-3623.

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

- Office Notes:
- Labs/Studies:
- Radiology Reports:
- Sensitive Information (examples include: STD Testing, HIV testing, etc)
- Immunization Record
- Growth Charts
- Other

This purpose of this disclosure is:

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

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. I further understand that the requested physician may submit a charge that will be billed to the undersigned for the copying/transferring of the medical information.

Signature: _____ Date: _____
Relationship to patient: _____

Unless otherwise specified below, this consent will automatically expire after one year from the date above.
Signature: _____ Request consent to expire: _____