Medical Records Release

Please complete the following form to request records from any other offices that your child has been seen at. Please include any emergency room or urgent care visits in the last 12 months.

We cannot schedule new patient well-child appointments prior to receiving medical records.

(This does not apply to newborns.)

Patient Name: _______________________________ Date of Birth: _______________________

Address: ____

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: ____

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Phone number: _______________________ **Fax number (required):** _______________________

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 office administrator, 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: __________________