Authorization to Use and Disclose Protected Health Information

(New patients Requesting Records from outside Capital Area Pediatrics)

□ I hereby authorize you to release the medical information requested below for my child who is less than 18 years of age:

Patient's Name: _____ **DOB**: _____

Current Address: _____

_____

Phone Number:_____

_____ **Immunization Record & Last Physical Exam** _____ **Complete Medical Record**

Date of Service *From*: _____ *To*: _____ □ Yes □ No ***I want the confidential information included with the record.***

Release Medical Records From:

Practice /Provider Name: _____

Address: _____

_____

Phone _____ **Fax** _____

Disclose Medical Records To:

☐ Please **fax** records to Central Business office (fax# 703-383-9574)

☐ Send electronically via Secure File Share

Capital Area Pediatrics **407 N Washington St** **Suite #100** **Falls Church VA 22046** **FAX: (703) 241-1863**	**Capital Area Pediatrics** **12950 Highland Crossing Dr** **Suite H** **Herndon VA 20171** **FAX: (703) 860-1528**	**Capital Area Pediatrics** **43480 Yukon Dr** **Suite 206** **Ashburn VA 20147** **FAX: (703) 729-2736**	**Capital Area Pediatrics** **6565 Arlington Blvd** **Suite 210** **Falls Church VA 22042** **FAX: (703) 938-3669**	**Capital Area Pediatrics** **410 Maple Ave W** **Suite 5** **Vienna VA 22180** **FAX: (703) 938-3669**

Duration: This authorization will remain valid for one year from the date of your signature.

Revocation: I UNDERSTAND that I may revoke this authorization at any time (in writing) except to the extent that action has been reliant on it. To revoke the authorization, please provide a written statement to the Office Manager of your child's (or your) primary office.

Re-disclosure: I UNDERSTAND that the information used to disclose pursuant to this authorization may be subject to re-disclosure and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.500 and 42 CFR Part 2.

Signature of Parent/Guardian: _____

Date of Request: _____ **Relationship to Patient**:_____