



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:

Capital Area Pediatrics 407 N Washington St Suite #100 Falls Church VA 22046 (703) 237-5919 FAX: (703) 241-1863	Capital Area Pediatrics 12950 Highland Crossing Dr Suite H Herndon VA 20171 (703) 860-4200 FAX: (703) 860-1528	Capital Area Pediatrics 43480 Yukon Dr Suite 206 Ashburn VA 20147 (703) 723-3201 FAX: (703) 729-2736	Capital Area Pediatrics 6565 Arlington Blvd Suite 210 Falls Church VA 22042 (703) 534-1000 FAX: (703) 938-3669	Capital Area Pediatrics 410 Maple Ave W Suite 5 Vienna VA 22180 (703) 938-2244 FAX: (703) 938-3669
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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:** _____