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 Information

Name: ____________________ **DOB**: ____________

Current Address: ____________________

____

Phone Number: ____________________

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 mail records to the following address: (*circle location*)

Capital Area Pediatrics	Capital Area Pediatrics	Capital Area Pediatrics	Capital Area Pediatrics	Capital Area Pediatrics
407 N Washington St	12950 Highland Crossing Dr	43480 Yukon Dr	6565 Arlington Blvd	410 Maple Ave W
Suite #100	Suite H	Suite 206	Suite 210	Suite 5
Falls Church VA 22046	Herndon VA 20171	Ashburn VA 20147	Falls Church VA 22042	Vienna VA 22180

• Capital Area Pediatrics Medical Records • *p.* (703) 359-5146 • *f.* (703) 383-9577 •

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**: ____________________