Authorization to Use and Disclose Protected Health Information

(Records Release Form)

□ I hereby authorize you to release my medical records (patients who are 18 years of age and older)
□ I hereby authorize you to release the medical information requested below for my child who is less than 18 years of age:

Name: ____ DOB: ______________

Current Address: ____

Phone Number:______________

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

Reason for request for copy of records:
□ Copy for personal record Other: ____

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□ Moving out of the area (Provide new address if different from above): ______________________________

□ Dissatisfied with the Practice? Please explain: ____

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Release of records will be processed within fifteen **(15)** days of receipt of this request at the practice. Charges associated with copying the medical records follow HIPAA HiTech Law (45CFR164.524) and Code of Virginia (32.1-127.1:03, 8.01-413). Payment is expected at the time of record receipt. Payment options include cash, credit cards, or check payable to Capital Area Pediatrics, Inc.

Please check appropriated box(es) below (OFFICE STAFF WILL COMPUTE FINAL CHARGE)

□ **Immunization Record** No Charge
□ **Mini Record (Immunization Record, Last PE)** No Charge
□ **Medical Records via Portal (Download Link)** Labor Charge: $5.00 per quarter hour:__________

□ **Complete Medical Record on CD**
Number CD's Requested: [ ]

CD Labor Charge: $5.00 per quarter hour: __________

CD Disk Charge: $1.00 per CD: __________

Postage to Mail CD: __________

TOTAL CD CHARGE: __________

TOTAL CHARGES BILLED: __________

□ **Complete Medical Record (Paper)**

Paper Record Charge: $0.15 per page: __________

Paper Record Postage: (First Class): __________

TOTAL PAPER RECORD CHARGE: __________

* *All postage fees are based on current USPS postage rates.*

□ Please mail records to the following address:

____

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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 reliance 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 patient (required if 18 years of age or older) parent/guardian: ______________________________

Date of request: __________ Relationship to Patient:______________________________