Authorization to Use and Disclose Protected Health Information

(Medical Records Release Form)

Submit All Medical Records Requests To: medicalrecords@capitalareapediatrics.com

(1) I, the undersigned, hereby authorize Capital Area Pediatrics, Inc. to use and/or disclosure the below named individual's health information

Name: _____ DOB: _____

Current Address: _____

Phone Number: _____ Email Address: _____

Date(s) of Service: From: _____ To: _____

(2) For the purpose of/medical records request reason:

□ Self/Personal record □ Other: _____

□ Continued Medical Care/New Pediatric Practice Selected

□ Relocating out of CAP coverage area

(3) Release of records will be processed within fifteen (15) days of receipt of this request. 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). There is a $20 Search and Handling Fee, in addition to other charges outlined below, depending on your selections. Payment is expected with record request via credit card.

(4) Provide the medical records by means of:

□ **Medical Records are to be sent to the following email address: _____**
Please note, medical records will be sent via encrypted email.

□ **Medical Records are to be downloaded onto a CD-Rom and mailed to: _____**
Please note, in addition to the $20 Search and Handling Fee, an additional fee of $1/CD as well as the cost of postage will be incurred.

□ **Medical Records are to be printed on paper and mailed to: _____**
Please note, in addition to the $20 Search and Handling Fee, additional fees of $0.50 per page (for a maximum of 50 pages or $25; if request exceeds 51 pages, the request must be fulfilled via CD-Rom option/charges) as well as the cost of postage will be incurred.

TOTAL MEDICAL RECORDS CHARGE(s): **Search and Handling Fee: $ 20.00**

CD-Rom(s): $ _____($1/CD)

Postage Costs: $ _____

TOTAL DUE: $ _____

(5) I UNDERSTAND the above-named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where appliable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 41 CFR Part 2.
(6) I UNDERSTAND that I have the right to revoke this authorization at any time and must do so in writing to: medicalrecords@capitalareapediatrics.com. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. **This authorization will expire within six months from the date of my signature.**
(7) 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.
(8) I UNDERSTAND that authorizing the disclosure of this health information is voluntary. I understand that there are fees associated with this request.
(9) I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information. I understand it can take up to thirty days to process this request and understand the costs associated with my request. **NOTE: If patient is of legal age (18), patient will need to sign the release themselves.**

_____ _____ _____
Signature of Patient Signature of Parent or Legal Guardian Date

_____ _____
Email Address Print Name of Parent or Legal Guardian

Revised 2/23