Medical Records Release

To Send Patient Records to Our Practice

Please complete the following information:

Patient(s) Name: _____

Patient(s) DOB: _____

Patient(s) Phone number: _____

I, _____, the parent or guardian authorize the records of my child(ren), to disclose/release the following information (Check all that apply) *:

- ☐ Immunization Records
- ☐ Clinical Records
- ☐ Laboratory/Pathology Records
- ☐ X-ray/Radiology Records
- ☐ Billing Records
- ☐ Psychotherapy

***Please provide the following information for the Provider you would like Medical Records Sent From:**

Name of Practice/Hospital/Provider: _____

Address: _____

Phone: _____ Fax: _____

Send Records to The Pediatric Center At the following office address (Check One):

☐ The Pediatric Center
West End – John Rolfe
2304 John Rolfe Parkway
Henrico, VA 23233
Phone: (804) 741-4404
Fax: (804) 750-1675

☐ The Pediatric Center
VCC – Virginia Center Commons
10571 Telegraph Road Suite 110
Glen Allen, VA 23059
Phone: (804) 266-9616
Fax: (804) 261-4935

☐ The Pediatric Center
East End - Laburnum
4786 Finlay Street
Richmond, VA 23231
Phone: (804) 226-4100
Fax: (804) 222-9508

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Printed name of patient representative **Representative's authority to sign for patient**

For Office Use Only

Date Received: _____ By: _____ Office Location: _____

Date Picked Up: _____ Date Scanned: _____ Date Faxed: _____ Completed By: _____

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