Clinical Form and Letter Release

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): :

- ☐ Asthma Action Plan ($10.00)
- ☐ Letter of Medical Necessity ($10.00)
- ☐ Camp/Scout Physical ($10.00)
- ☐ FMLA ($25.00)
- ☐ College Form/TB risk assessment ($10.00)
- ☐ Daycare/School Entrance Form ($10.00)
- ☐ Certified Immunization Records ($10.00)
- ☐ Allergy Action Plan ($10.00)

Pick-up Location (check one): ☐ John Rolfe Pkwy ☐ Virginia Center Commons ☐ Laburnum
☐ Mail (parent/guardian must provide a self-addressed and stamped envelope)

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/Parent/Authorized Representative | Printed name of Patient/Parent/Authorized Representative | Date

Completed forms may be submitted by fax to 804-294-5954 or dropped off at the front desk of any of our offices.

For Office Use Only

Date Received: _____ By: _____ Office Location: _____

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

☐ Paid
☐ Not Paid
☐ Faxed-Not Paid

04222025-0