the pediatric center
CARING FOR RICHMOND'S CHILDREN SINCE 1962

Medical Records 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):

- ☐ Immunizations Records
- ☐ Clinical Records
- ☐ Laboratory/Pathology Records
- ☐ Psychotherapy
- ☐ X-ray/Radiology Records
- ☐ Billing Records
- ☐ Other: ______________________
- ☐ Social Security

Send to Third Party/New Provider: ☐ Mail

No charge for the initial Third-Party Requests such as a new provider, new practice, specialist, hospital, insurance company, etc.

Third Party/Provider Name: ______________________________

Address: ______________________________ ______________________________ ________ ________

Street/Suite City State Zip

Phone: ______________________________

Personal Pick-Up Location: ☐ John Rolfe Pkwy ☐ Virginia Center Commons ☐ Laburnum

Request for Records for Patient's Personal Use is a $10.00 flat fee plus $.50 per page up to fifty pages then $.25 for pages fifty-one and above.

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 804-592-4447 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 ☐

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