Reston Town Center Pediatrics

Medical Records Release Form

Authorization for the Release of Protected Health Information

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. **There will be a fee for the requested records. Please allow a minimum of 2-3 weeks for processing.**

PATIENTS 18 YEARS OF AGE ARE CONSIDERED ADULTS AND THEREFORE MUST REQUEST THEIR OWN MEDICAL RECORDS*

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Providing Information:
Reston Town Center Pediatrics
1830 Town Center Dr. Suite 205
Reston, VA 20190
Phone: 703-435-3636
Fax: 703-435-9145

Mailing Address:
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
***Records will not be faxed or e-mailed.

Please check appropriate box(es) below:

☐ All Medical Records ☐ Specific dates of service, from: ____/____/____ to ___/____/____

Reason for Release: check all that apply

☐ Change of Doctors ☐ Relocating ☐ Consultation with another doctor ☐ Personal Use ☐ Other

☐ Dissatisfied with the Practice. Please explain_____

_____

_____

All Records-Fee: $25 for copying standard record transfer (last 2 years including consults), for entire chart $35 fee and additional .50cents per page for first 50 pages; .25cents a page thereafter. $20 for retrieval of immunizations records from storage, and $35 for a chart retrieval from storage.

☐ I would like my child's records mailed. I understand there is an additional $10 handling/mailing fee.

☐ I will pick up my child's records

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)