RESTON TOWN CENTER PEDIATRICS

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM ANOTHER FACILITY

I hereby grant permission to:

NAME OF FACILITY/PROVIDER: _____
STREET: _____
CITY/STATE/ZIP/COUNTY: _____ release a copy of my medical records. I understand that the information released upon authority of this authorization may contain information concerning treatment for a sexually transmitted disease, alcohol, drug abuse, a psychiatric condition, or HIV test results, an AIDS diagnosis, or AIDS-Related condition. I further understand this authorization does not include permission to release outpatient Psychotherapy notes. The release of Psychotherapy notes requires a separate authorization (Psychotherapy notes are separated from the rest of a patient's medical record). This authorization is valid for a period of 60 days from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance.

FOR THE PURPOSE OF THIS RECORD TRANSFER IS:

- o Patient Care
- o Other: _____

The copy of the medical records is to be released to: ATTN: Reston Town Center Pediatrics
1830 Town Center Drive, #205
Reston, VA 20190
(703)-435-3636
Fax: (703) - 435-9145

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT ADDRESS: _____

TELEPHONE NUMBER: (_____) _____
PATIENT'S SIGNATURE: _____ DATE: _____/____/_____
If patient is deceased, administrator of patient's estate or nearest relative may sign. If patient is a minor, parent or legal guardian must sign below. Please attach supporting, legal documentation. Signature of Authorized Representative (Please state relationship): _____ (_____) DATE: _____/____/_____