

Reston Town Center Pediatrics  
1830 Town Center Dr. Ste 205  
Reston, VA 20190



Phone (703) 430-3636  
Fax (703) 435-9145  
WWW.RTCPEDS.COM

### REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

- NOTE:**
1. Please allow 15 business days for the records to be processed and released.
  2. Charges associated with copying medical records follows HIPAA HiTech Law (45CFR164.524)
  3. Records request charges and any outstanding balances MUST be paid before releasing full medical records

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Best phone number: \_\_\_\_\_

**Reason for Requesting Records: (please circle)**

1. Moving out of area
2. Not leaving the practice, obtaining medical records for personal files
3. Child has aged out of practice
4. Requesting records for a specialist or consultation
5. Leaving practice for another provider (please explain) \_\_\_\_\_  
\_\_\_\_\_
6. Other: \_\_\_\_\_  
\_\_\_\_\_

**Please select: WE DO NOT EMAIL OR FAX MEDICAL RECORDS**

Portal \_\_\_\_\_

PICKUP \_\_\_\_\_

MAIL **There is an additional \$10 mailing fee**

Mailing address for Records:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this a permanent transfer?    Yes    or    No

**Charges: There is a fee for obtaining medical records:**

\_\_\_\_\_ No Charge: Last Physical & Immunization Records

\_\_\_\_\_ \$20 Electronic Copy

\_\_\_\_\_ \$50 Paper Copy of Full Medical Records

\_\_\_\_\_ If your chart is retrieved from our offsite storage, there will be an additional \$30 fee for obtaining your records.

**\*\*\* Pricing subject to change due to size of chart. Additional mailing charges may apply**

I hereby RELEASE and AUTHORIZE Reston Town Center Pediatrics to release all medical records of the patient(s) listed (or SELF if over the age of 18) including diagnosis, treatment, prognosis and recommendation, as well as other data pertinent to the patient's treatment.\*\* I hereby state that I am the child's parent or legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child(ren), and that my parental authority has not been terminated or restricted by the courts. **\*\*Reston Town Center Pediatrics only releases medical records to patients, parents of patients or authorized representatives.**

\_\_\_\_\_  
(Parent/Patient/Guardian or Authorized Representative Signature)

OFFICE USE ONLY: PAID    SCANNED REQUEST    PT QUESTIONNAIRE

CALLED/LEFT VM

PROVIDER REVIEW \_\_\_\_\_ INACTIVE

DATE COMPLETED \_\_\_/\_\_\_/\_\_\_ BY \_\_\_\_\_