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

RTC Pediatrics
We care for kids

Phone (703) 435-3636
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: _____

Please select: WE DO NOT EMAIL OR FAX MEDICAL RECORDS

Portal _____
PICKUP _____
MAIL **There is an additional $10 mailing fee**
Mailing address for Records:

_____

_____

_____

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: _____
   _____

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 COMPLTED____/____/_____ BY _____