# RVA Pediatrics

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## General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____ Date of Birth:_____/_____/_____

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Patient Name: _____ Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

☐ All records ☐ Laboratory/pathology records ☐ X-ray/radiology records ☐ Abstract/Summary
☐ Pharmacy/prescription records ☐ Other (describe specifically)_____

### Requested from:

Name:_____
Address:_____
_____
Phone: _____
Fax: _____

### Transferred to:

Name: _____
Address: _____
_____
Phone _____
Fax: _____

**Please tell us why you are leaving our practice:**

I understand that once this information is released by our office, the information may be subject to disclosure by the party information has been sent to and may no longer be protected by federal or state law.

_____ _____ _____

Print name of patient or guardian | Signature of patient or guardian (relationship) | Date

**PLEASE FAX TO THE BUSINESS OFFICE 804-754-0880**