

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: ____/____/____

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

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:

Transferred to:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone _____

Fax: _____

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