WOODBRIDGE PEDIATRICS, LTD
1924 Opitz Blvd
Woodbridge, VA 22191
703-494-1144
Fax 703-494-5647

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Each patient must have a separate release form.

Patient Full Name_____ **DOB**_____ **Account #**_____
Phone #_____

I hereby RELEASE and AUTHORIZE Woodbridge Pediatrics, Ltd to release the Protected Health Information/medical records of the dependent listed above (or self if over the age of 18). 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 and that my parental authority has not been terminated or restricted by the courts. I understand that I may revoke this authorization in writing at any time but it will not affect any information released prior to notification of cancellation.

Signature :_____ **Print Name:**_____ **Date:**_____

The information to be disclosed relates to service dates beginning_____and ending _____.

Please indicate which records you are requesting.

□ Entire medical record	□ Immunizations	□ Test Results
□ Well Baby / PE visits	□ Progress notes	□ Consultations
□ Billing Records	□ Other_____	

Please indicate if there is any information you would **NOT** liked copied_____

Reason for Request:_____
Are you permanently leaving the practice? Yes_____ No_____

There is a $30.00 retrieval and processing fee for each patient record copied. All fees must be collected prior to records being released.

Would you like to □ **PICK UP** Medical records or □ **MAIL Records to :**

Name:_____
Address:_____
City:_____ State:_____ Zip:_____

Official Use Only

Processed by:_____ Date records mailed/picked up_____
Date fee collected:_____