301 Gristmill Drive Forest, Virginia 24551 434-385-7776 fax: 434-385-5846

Release of Medical Information

AUTHORIZATION to Release, Obtain and/or Exchange written Protected Health Information **and** Verbal Communication

1. Patient Name _____ **Date of Birth** _____ **Date**_____

Phone_____**Address**_____**Chart #**_____

2. Exchange of Information between:	**3. And:**
LYNCHBURG PEDIATRICS	**Office Name:**
301 Gristmill Drive	**Address:**
Forest, VA 24551	
Phone 434-385-7776	**Phone:**
Fax 434-385-5846	**Fax:**

4. Information to be disclosed Dates of service from_____To_____

( ) Written and Verbal Documentation: Including leaving voicemail

( ) ALL () Office Notes ( )Labs/Xray ( )Immunization record ( )Newborn records ( ) Newborn screen ( ) Emails and/or text messages about appointments and referrals () Other_____

4a. Federal and State Law require special permission to release certain information. Please check if these records should be released.

( ) Mental Health ( ) Alcohol/drug abuse ( ) HIV/Aids test results ( ) Developmental Disabilities

5. Purpose of Release

( ) Care Coordination and Treatment Planning ( ) Moving to: (New Address**)** _____
( ) Change of insurance to: _____ ( ) Transferring care to Dr. _____
( ) Other_____

6. Release format: ( ) Paper ( ) Mail ( ) Faxed or ( ) Pick up; Electronic with ( ) Encrypted email ( ) FMH portal ( ) Direct messaging

7. Expiration

This authorization will expire one year from the date of my signature below, unless otherwise indicated here: _____/_____/_____.

8. Signature

I authorize the use and/or release of my or my dependents protected health information as described below by Lynchburg Pediatrics. I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this authorization by providing written notice to Lynchburg Pediatrics. Revocation of this authorization will not affect any action taken before receipt of the written revocation.

I agree to pay any fees for copying and/or summarizing my protected health information or any medical reports. The state of Virginia allows 30 days for transfer of medical records.

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider and/or affiliates may use and/or disclose to the persons and/or organizations named in this form the protected health information described in the form.

Signature_____ **Date**_____

Printed Name_____ **Relationship to Patient** _____