



Consent to Release FROM The Pediatric Group
(For patients 18 and older)

Each form MUST be completely filled out and contain a signature in order to be processed.
Please **PRINT** all information except **SIGNATURE**.

Date Of Request _____

Patient Name _____

Date of Birth _____

I understand that by signing this form, I am allowing the medical information concerning the above patient, to be released.

Name and Address of Physician or Practice to which the Medical Information should be sent:

Please FAX Information to: (_____) - _____

From:

Lake Ridge Office

13001 Summit School Rd.
Lake Ridge, VA 22192
(703) 494-4811

Fairfax Office

10334 Fairfax Boulevard
Fairfax, VA 22030
(703) 425-3300

Alexandria Office

6354 Walker Lane, #210
Alexandria, VA 22310
(703) 971-6900

Chantilly Office

3914 Centreville Rd, #101
Chantilly, VA 20151
(703) 481-8600

As per my request, the reason for releasing the information is:

_____ Continued Medical Care _____ Legal _____ Insurance _____ Other

I understand that the information to be released may include information in the following categories, unless I specifically deny the release (initial ANY category NOT to be released).

_____ Substance Abuse _____ Mental Health _____ HIV Related Information

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

Signature of Patient (for patients over age 18)

Date

Patient's Complete Mailing Address:

Patient's Day Time Phone Number

A record transfer and copy fee of \$25 per person must be paid prior to records being copied by TPG Pediatrics.

