Consent to Release Information TO TPG Pediatrics
(For Patients UNDER age 18)

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

Lake Ridge Office	**Fairfax Office**	**Alexandria Office**	**Chantilly Office**
13001 Summit School Rd.	10334 Fairfax Blvd	6354 Walker Lane, #210	3914 Centreville Rd, #101
Lake Ridge, VA 22192	Fairfax, VA 22030	Alexandria, VA 22310	Chantilly, VA 20151
(703) 494-4811	(703) 425-3300	(703) 971-6900	(703) 481-8600

E-fax Number - (855) 308-2338

Name, **Address** and **FAX Number** of Physician Releasing the Medical Information:

_____

_____

FAX Number (_____) _____ - _____

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 Parent/Legal Guardian Date

_____
Relationship to Patient

_____
Witness Signature

Patient's Complete Mailing Address:
_____

Parent/Legal Guardian's Day Time Phone Number _____