Consent to Release FROM The Pediatric Group

(For patients UNDER the age of 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 _____
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	**Fairfax Office**	**Alexandria Office**	**Chantilly Office**
13001 Summit School Rd.	10334 Fairfax Boulevard	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

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 (for patients under age 18) Date

_____
Relationship to Patient

_____
Relationship to Patient

Patient's Complete Mailing Address:

_____

_____

_____

_____

_____
Parent/Legal Guardian's Day Time Phone Number

TPG Pediatrics

A record transfer and copy fee of $25 per child, or $35 per family of two or more medical records must be paid prior to records being copied by The Pediatric Group.

Updated 6/2024