OFFICE (804)754-3776
FAX (804)754-2365

10410 RIDGEFIELD PKWY
RICHMOND, VA 23233

Authorization for Use and Disclosure of Protected Health Information – Medical records release

Patient name:_____ Date of birth:_____

Address:_____ City,State,Zip:_____

Phone number:_____

__All records

__Dates of service: From:_____ To:_____

__Immunization records ONLY

Reason for records transfer:

__ Self/Personal __ Moving __ Aged out of Pediatrics

__ Other (please list reason): _____

Please note: records will be processed within 30 days of receipt of signed request. **There is a $50 Search and Handling fee** as allowed by HIPAA HITech Law (45CFR164.524) and Code of Virginia (32.1-127.1:03,8.01.413) for outgoing records.

Please release records in the following format:

__Records in PDF format on CD-Rom or Flashdrive (circle one)

__Records printed to paper (*additional fees may apply)

__Records faxed to:_____ (limited to 30 pages, over 30 pages will be on thumbdrive)

__Records emailed to:_____ (will be sent via encrypted email)

*In addition to the Search and Handling fee of $50, there will be an additional charge of $.50/page for the first 50 pages then $.25/page for the remaining pages plus the cost of postage for paper records.

Records should be transferred <u>to</u> (if leaving our practice) or <u>from</u> (if joining our practice):

Name:_____

Mailing address:_____

City,State,Zip:_____

Phone:_____Fax:_____

I, the undersigned, hereby authorize RVA Pediatrics, PC, to use and/or disclose the above-named individual's health information. I **understand** this may include information relating to sexually transmitted diseases, genetics, sexual activity, including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and/or alcohol abuse in accordance with 41 CFR Part 2. I **understand** that the information disclosed by this authorization may be subject to re-disclosure and therefore no longer protected under the HIPAA regulation. I **certify** that I am the patient, the patient's parent, or legal guardian with the authority to authorize disclosure of the above-named patient's protected health information. I **understand** that there is a fee associated with this disclosure and that I will be responsible for that fee. I reserve the right to revoke this authorization at any time by written request to: RVA Pediatrics, PC, 10410 Ridgefield Pkwy, Richmond, VA 23233.

**If the patient is of legal age (18), the patient will need to sign this form themselves.

_____ _____ _____
Patient Signature (18 or over) Parent/Legal Guardian signature Date

_____ _____
Email address Print Name of Parent/Legal Guardian