RVA Pediatrics, P.C.

PERMISSION TO DISCUSS PHI
(other than the parent)

Patient Name: ____________________________________

Date of Birth: ____________________________________ Account #: ___________

I, ____, parent or guardian of ____, a minor, hereby give permission for the following people to have access to my child's personal health information, including, but not limited to, medical records, treatment plans, immunizations, test results, and prescriptions, both written, verbal, or electronically transmitted:.

- ___________________________________ /_________________ relationship
- ___________________________________/ _________________ relationship
- ___________________________________/ _________________ relationship
- ___________________________________/ _________________ relationship

☐ **I do not give permission to discuss my account with anyone other than myself.**

I understand that I may revoke this authorization at any time by sending written notification to: RVA Pediatrics, P.C., 10410 Ridgefield Parkway, Richmond, VA 23233.

I understand that once any information is disclosed to a third party listed above, RVA Pediatrics, P.C. is not liable for any re-disclosure by that party and the information may no longer be protected by federal or state law.

____
Signature of Parent or Guardian (or child over 18 years of age)

____
Date