7113 Three Chopt Rd. Suite 101
Richmond, Va 23226
Fax: (804) 673-6432

Pediatric Associates of Richmond, Inc.

Call Center: (804) 282-4205

8485 Bell Creek Road, Suite B-3
Mechanicsville, Va 23116
Fax: (804) 559-9227

HIPAA Compliant: Authorization to Release Health Information

I hereby authorize Pediatric Associates of Richmond to release medical records and data pertaining to:

Patient Information

Last Name:	First Name	Middle Initial	Birth Date
Last Name:	First Name	Middle Initial	Birth Date
Last Name:	First Name	Middle Initial	Birth Date

Release Information From:

☐ Pediatric Associates of Richmond, Inc.

☐ Other (S*pecify facility/individual and address below, including phone/fax if known*)

Release Information To:

☐ Pediatric Associates of Richmond, Inc., **Three Chopt** location
☐ Pediatric Associates of Richmond, Inc., **Bell Creek** location
☐ Other (S*pecify facility/individual and address below, including phone/fax if known*)

Purpose of Release:

☐ Treatment/Continued Care ☐ Transfer of Care
☐ Other (*Please Specify*):

If PAR is releasing records, please specify the desired method for the release.

Printed Records: ☐ Pick-up ☐ Fax (up to 10 ps) ☐ Mail

CD (full records only): ☐ Mail ☐ Pick-up

Information to be Released:

Service Dates (*Optional*)
From: To:

Information Needed By
Date:

☐ Immunization Records
☐ Other (*Please Specify*):
☐ Last Well Visit
☐ Full Medical Records
☐ Billing Information

I understand the information to be released under this authorization may include information or records relating to the diagnosis, treatment or other therapy for the condition(s) of infection with the human immunodeficiency virus (HIV), sickle cell anemia, drug abuse, alcoholism, alcohol abuse, psychotherapy notes, or genetics, except as limited below:

PLEASE ALSO COMPLETE THE SECOND PAGE. THANK YOU!

Notice of Rights

I authorize the release of the health information described above and **understand** that:

1. I have the right to revoke my authorization at any time by submitting a written and signed request to Pediatric Associates of Richmond, Inc. at 7113 Three Chopt Road Suite 101, Richmond, VA 23226, Attn: Privacy Officer. I also understand that any revocation of this authorization will not be effective in cases where Pediatric Associates of Richmond, Inc. has already relied on it to use or disclose health information.
2. The information released in response to this Authorization may be re-disclosed to other parties. Once information is disclosed pursuant to this Authorization, I understand that the federal privacy law protecting health information may not apply to the recipient of the information and, therefore, I am aware that Pediatric Associates of Richmond, Inc. cannot control how the recipient uses or shares the information.
3. I may refuse to sign this Authorization and this refusal will not affect the treatment or payment Pediatric Associates of Richmond, Inc. provides to the patient.
4. I have the right to inspect and receive (upon reasonable notice and for a reasonable fee, subject to any legal limitations) a copy of the material to be disclosed as well as a copy of this authorization form.
5. I understand that Pediatric Associates of Richmond, Inc. has the right to deny me access to the records in certain circumstances in accordance with the law. If Pediatric Associates of Richmond, Inc. denies me access to requested medical information, I understand they will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.
6. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.

Pediatric Associates of Richmond, Inc. may impose a fee for providing medical records as provided for by state law.

This authorization will **expire one year** from the date of signing, unless earlier revoked in the manner provided above, or unless I indicate an earlier date or event here:

_____

_____

Signature

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

  ☐ Legal Guardian ☐ Health Care Agent (Health Care Power of Attorney) ☐ Other:_____
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

  ☐ Parent ☐ Legal Guardian ☐ Divorced/Legally separated/Joint Custody: Please provide legal documents indicating your right to the patient's medical records

Signature (required)	Date Signed

Printed Name of Person Signing	Relationship, if not the Patient	Phone Number

Office Use only:

Completed by: _____

Date Records picked-up/faxed/mailed: _____

Cash: _____ Check: _____ Credit Card: _____ Invoice provided to patient: _____