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PATIENT AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION

Provide the patient with a copy of the signed form

****** THE REQUESTED INFORMATION WILL NOT BE RELEASED WITHOUT THE APPROPRIATE SIGNATURE ******

Patient's Legal Name | Date of Birth

I request & authorize West End Pediatrics, PC to release health care information on the patient named above to:

NAME:

(relationship to patient) :

ADDRESS:

- ☐ MAIL TO ABOVE ADDRESS
- ☐ ABOVE NAMED PERSON TO PICK UP
- ☐ FAX (limited / urgent only) # ________________
- ☐ OTHER

This authorization applies to the following information:

- ☐ ALL RECORDS (mail or pickup only)
- ☐ SHOTS ONLY
- ☐ DATE(S) OF SERVICE: ____________
- ☐ OTHER:

Protected Health Information is being used or disclosed for the following purpose:

- ☐ CAMP
- ☐ DAYCARE
- ☐ SPORTS
- ☐ SCHOOL
- ☐ AUTO ACCIDENT
- ☐ LIFE INSURANCE
- ☐ OTHER: ______________________

THIS AUTHORIZATION EXPIRES ON ____________

OR WHEN THE FOLLOWING EVENT OCCURS:

(ex. "until further notice , 12/31/2020, etc.)

CHARGES FOR COPYING MEDICAL RECORDS You have requested that West End Pediatrics, P.C. either release your medical information or a summary of your information to a person or entity outside of our practice or that you would like to have a copy of your medical records. In accordance with the law, West End Pediatrics, P.C. may be able to charge you a reasonable fee for this service regarding non-subpoenaed medical records. **1)** For copies from paper or other hard copy generated from computerized or other electronic storage, West End Pediatrics, P.C. charges: 50 cents per page for first 50 pages; 25 cents per page for additional pages **2)** Cost of shipping / postage. **3)** $10.00 / form for completing school, daycare, sports, etc. forms. If medical records are subpoenaed, the party causing the subpoena is responsible for payment of the rates listed above under #1. If you feel you cannot afford to pay our posted charges, please call our Business Office (804) 740-2527 to discuss a payment plan or an alternative arrangement. Thank you.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that West End Pediatrics, P.C. has relied on my authorization: I understand that to revoke this authorization, written notification should be sent to:

Privacy Office, West End Pediatrics, P.C. 9606 Patterson Avenue Richmond, VA 23229

I understand that once this information is released by West End Pediatrics, P.C., the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law. I understand that West End Pediatrics, P.C. will not condition my treatment on whether I provide authorization for the requested use or disclosure. If applicable, signing this authorization may result in permission for my physician to receive direct or indirect payment to West End Pediatrics, P.C. from a third party based on the use or disclosure of my medical information.

Signature of Parent, Patient or Legal Guardian | **Date**

Print Name | **Relationship to Patient**

Revised 2-11-2013