AUTHORIZATION FOR RELEASE OF INFORMATION

_____20_____

I, _____ authorize _____ to release the information

circled below to Piedmont Pediatrics, 900 Rio East Court, Ste. A, Charlottesville, VA 22901, 434-975-7777,

fax 434-975-7774.

Discharge Summary	History and Physical	Laboratory Report	Radiology report
Pathology Report	Emergency Room Report	Consultation Report	Operative Report
Entire Record	Billing & Payment History	Other_____	

Dates of Service: _____

Patient Name: _____

Date of Birth: _____ Social Security Number:_____

Phone Number: H:_____ W:_____

Purpose of Request: Personal Use - Continuing Care - Other_____

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include, if applicable, PSYCHIATRIC, DRUG/ALCOHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have to right to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or other person, or when the revocation is not permitted by law.

Special Instructions:_____(none if blank)

_____ _____

Signature of Patient or Legal Representative Date

_____

If signing by Legal Representative, indicate relationship to patient.

This authorization is only valid for the information/purpose(s) indicated above and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.