

**PEDIATRICS OF ARLINGTON PLC**

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION TO THIRD PARTIES  
(TRANSFER OF RECORDS TO ANOTHER PHYSICIAN)**

By signing this authorization, I authorize Pediatrics of Arlington, PLC to use and/or disclose certain protected health information (PHI) about my child.

This authorization permits Pediatrics of Arlington PLC to use or disclose to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

the following individually identifiable health information :

Immunization records \_\_\_\_\_ Problem list summary \_\_\_\_\_

Birth records \_\_\_\_\_ Consultations \_\_\_\_\_

Progress notes \_\_\_\_\_

This authorization will expire on \_\_\_\_\_  
{Expiration Date or Defined Event}

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Pediatrics of Arlington PLC has acted in reliance upon this authorization. My written revocation must be submitted to Pediatrics of Arlington, PLC at 1715 N. George Mason Dr. #205, Arlington, VA 22205.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth