PEDIATRICS OF ARLINGTON, PLC

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Pediatrics of Arlington, PLC to use and/or disclose certain protected health information (PHI) about my child/myself. I am aware that there is a fee associated with this request and that I am responsible for payment. 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 _____

Growth and development charts _____ Consultations _____

Birth records _____

Reason for transfer of records:

Relocation out of area _____ Insurance change _____ Personal use _____

Consultant use _____ Transfer of care (explain) _____

_____

When this information is used or disclosed pursuant to the 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 event that Pediatrics of Arlington, PLC has acted in reliance upon this authorization. A written revocation must be submitted to Pediatrics of Arlington, PLC at 1635 N. George Mason Dr. #185, Arlington, VA 22205.

Signed by:

_____ _____ _____

Signature of Patient or Legal Guardian Relationship to Patient Phone Number

_____ _____

Name of Patient or Legal Guardian Date

Patient's Name: Date of Birth:

_____ _____