Fill out the information below and submit to: The Children's Clinic of Fredericksburg
4532 Plank Rd, Fredericksburg, VA 22407 or fax to: (540) 252-1841

I authorize The Children's Clinic of Fredericksburg:____________________

☐To release the information from the record of: ☐To obtain records from ____________________ on:

Patient Name:____________________ Social Security Number:____________________

Date of Birth:____________________ Daytime Phone Number:____________________

Address:____________________

Documentation can be released electronically if stored in an electronic media.

Preferred media: ☐Paper ☐CD

Dates of Service: ____________ to ____________

Information to be Released:

☐History & Physical Exam ☐ Discharge Summary ☐Radiology/Imaging Report
☐Health & PE Physician ☐Laboratory Report ☐Vaccination Records
☐Progress Notes ☐Psychiatric Records* ☐HIV Records*
☐EKG Report ☐Complete Chart*
☐Drug & Alcohol* ☐ Other:____________________

***Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.**

Person/Facility to Receive Information:____________________

Street:____________________ City:____________ State:_____ Zip Code: ______

This information is being disclosed for the following purpose:____________________

Authorization to Release Information:

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer (540) 252-1840.
2. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as:____________________(if none specified, this authorization will expire 6 months after the date specified below).
3. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied at a rate of: the first 50 pages, $0.50 per page and $0.25 per page thereafter, and microfilm is $1.00 per page.

Signature of Patient or Legal Representative: ____________________ Date:____________

☐Parent or Legal Guardian ☐Medical Power of Attorney ☐Next of Kin Deceased ☐Executor of Estate

Authorization to Release Confidential Medical Information

The Children's Clinic of Fredericksburg
Primary & Urgent Care
4532 Plank Rd., Fredericksburg, VA 22407
(540) 252-1840