F. Read Hopkins
Pediatric Associates, Inc.

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Phone: (434) 237-8886
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# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date:_____ Chart #:_____

**Patient Name:**_____ **D.O.B.**_____

Address_____ Daytime Phone:_____

Fathers Name:_____ Mothers Name:_____

| **Release From:**_____ | **Release To:**_____ |
|---|---|
| Name:_____ | Name:_____ |
| Address:_____ | Address:_____ |
| _____ | _____ |
| Phone:_____ | Phone:_____ |
| Fax:_____ | Fax:_____ |

Information to be released:_____

_____

Reason for Request:_____

Relocation (New Address):_____

_____

*I understand F. Read Hopkins Pediatric Associates, Inc. will provide a summary of my medical records or a copy* ***within 15 business days*** *of my request.* ***I agree to pay any fees for copying and/or summarizing my Protected Health Information.*** *I understand this authorization will expire in 90 days after it is signed unless another date is specified here*_____.

I have read and understand this authorization. I certify that I am the patient listed above or a person authorized to permit release of records on the patient's behalf. I hereby release F. Read Hopkins Pediatric Associates, Inc. from any liability or damages arising in connection with or related to the use and/or disclosure of my protected health information pursuant to this authorization.

**Signature:**_____ **Date:**_____

**Printed Name:**_____ **Relationship to Patient:**_____

**I.D. Verification:** _____

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**OFFICE USE ONLY**

Date mailed/picked up_____ Fees_____

REV. 2/2011