F. Read Hopkins Pediatric Associates, Inc.
1212 McConville Road ▪ Lynchburg, VA 24502
Phone: (434) 237-8886 ▪ Fax: (434) 239-6807

Protected Health Information Authorization Form

Patient's Name:	Date of Birth:

Address _____

City _____ **State** _____ **Zip** _____

Phone # _____ **Cell #** _____

I Authorize F. Read Hopkins Pediatric Associates, Inc. to:

☐ **RELEASE INFORMATION TO:** **or** ☐ **OBTAIN INFORMATION FROM:**

Name of Provider or Facility: _____

Address: _____

Phone #: _____ **Fax #:** _____ **(only fax less than 10 pages)**

PURPOSE FOR THIS REQUEST: (Check One)

☐ **Relocation** ☐ **Insurance Change** ☐ **Change of Provider** ☐ **Personal Use**

☐ **Other (specify)** _____

INFORMATION REQUESTED: (Check One) ☐ **Immunization Record** ☐ **Summary**

☐ **Specific Dates, Illness or Injury:** _____ ☐ **Laboratory or X-Ray Reports**

_____

☐ **Other (specify)** _____

I Understand That :

- I am giving permission to disclose information related to behavioral or mental health, alcohol/drug abuse, AIDS, HIV, etc. unless indicated here._____
- This authorization is valid for 12 months from the date of signature.
- I may cancel this authorization at any time by submitting a written notification, but that it will not affect any information released prior to notification of cancellation.
- The requested **information will be provided within 15 business days** of my request.
- **I agree to pay charges permitted by Virginia Law for copying and/or summarizing records.**
- I release F. Read Hopkins Pediatric Associates 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.
- It is the Parents/Patients responsibility to obtain records from a previous provider.

Signature: _____ **Date:** _____

(Patient Signature if over 18, Guardian Signature if under 18)

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

OFFICE USE ONLY:

rev. 7/2017

ID Verification:_____ Date picked up/mailed:_____ACCT # / MRN #:_____