F. Read Hopkins
Pediatric Associates, Inc.

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Lynchburg, Virginia 24502
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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:** **PickUp** ☐ **Mail To** ☐
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____

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:**_____

OFFICE USE ONLY

I.D. Verification: _____

Date mailed/picked up_____ Fees_____

REV. 07/2013