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

EACH PATIENT MUST HAVE A SEPARATE RELEASE FORM

Patient's Name:	Date of Birth:

Address _____

City _____ State _____ Zip _____

Phone # _____ Work # _____

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

☐ RELEASE INFORMATION TO:  ☐ OBTAIN INFORMATION FROM:

Name of Provider or Facility: _____

Address: _____

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

PURPOSE FOR THIS REQUEST: (Check)

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

☐ Other (specify) _____

INFORMATION REQUESTED: (Check) ☐ Immunization Record ☐ Summary

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

☐ Other (specify) _____

☐ I DO
☐ I DO NOT > Authorize release of information related to behavioral or mental health, alcohol/drug use, AIDS/HIV, etc.

SELECT THE FORMAT YOU WOULD PREFER: (Check)

☐ PAPER
- ☐ Mail to the above address
- ☐ Will pick up at the practice

☐ ELECTRONICALLY
- ☐ EMAIL ☐ CD
- Email Address _____

☐ FAX - FAX #: _____

☐ PATIENT PORTAL

I Understand That :

- 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 30 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. 1/2019

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