Authorization for Release of Medical Records

Find us on the web at: https://www.wpeds.com

Date: _____

Please note that there may be a charge for providing copies of your medical records as allowed by Federal & State Law

Medical Records of (Patient Information):

First:_____ Date of Birth:_____

Maiden/Middle:_____

Last:_____ Last 4 digits of SS #:_____

Address: Street Name:_____

City:_____ State_____ Zip Code_____

Telephone:_____ Email:_____

Return Completed Form to:

Winchester Pediatric Clinic
190 Campus Blvd., Suite 400
Winchester, VA 22601

Or

Fax To: 540-722-3373
Telephone:540-667-1727

RECORDS TO BE RELEASED FROM: Winchester Pediatric Clinic ("WPC"), 190 Campus Boulevard, Suite 400, Winchester, VA 22601

RECORDS TO BE RELEASED TO: I,_____request and authorize WPC to release my medical records as indicated below to:

Name of person or organization receiving records: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax:_____ Telephone:_____ Email:_____

***FORMAT & METHOD OF DELIVERY**: WPC will provide paper or digital/email copies of the requested records. Please indicate your preferred method of delivery:* _____

REASON FOR DISCLOSURE (*For the purpose of):*

☐ Continuing Care	☐ Referral to a Specialist	☐ Change of Doctor/Provider	☐ Personal
☐ Insurance	☐ Workers Comp	☐ Disability Determination	☐ Legal

INFORMATION TO BE RELEASED: At my request, I authorize disclosure of my health information as indicated below (*check all that those that apply*):

☐ **Date(s) of service:** From_____to _____ *If dates not indicated, only the past two years will be released.

☐	Provider notes	☐	X-ray reports
☐	Special Diagnostic test results	☐	Chemical/Alcohol Treatment records
☐	Lab reports	☐	ALL Medical Records:
☐	Immunization Records	☐	Other (specify)

☐ **Unless I HAVE LIMITED BELOW**, I understand that the release of records also pertains to those records regarding testing and treatment **for alcohol/substance abuse**, **human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease.** Or, Indicate **LIMITATIONS BELOW:**

1. Confine to **summary information** from records regarding treatment for following condition or injury:
   _____On or about (date(s) _____
2. Other: _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: Virginia Law permits a charge for personal copy/transfer of your records. CIOXHealth has been contracted to provide this service and will invoice you directly. Virginia Rates are $0.07 per page, plus actual postage/handling charges. Electronic delivery is flat rate $6.50. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

Patient Signature: _____ Date _____

Patient Legal Representative: _____ _____ _____ _____

*If not the parent signing, legal documentation must be attached.

Name) *(Relationship to patient)* *(Signature)* *Date)*

For Office Use

Date Received:_____ **Received by:** _____

Date Released:_____ Released by: _____

Updated: 12/21/2021