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 - Aged Out	☐ Referral to a Specialist	☐ Change of Doctor/Provider By choosing this option, your child will no longer be a patient of WPC. Pending appointments will be cancelled.	☐ 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: ______________ ______________ ______________ ______________

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

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

For Office Use

Date Received:______________**Received by:** ______________

Date Released:______________Released by: ______________

Updated: 04/26/2023