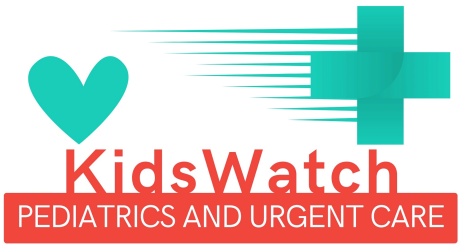

Medical Records Release Authorization

Patient Information:

- Patient Full Legal Name: _____
- Patient Date of Birth (MM/DD/YYYY): _____
- Patient Medical Record Number (if known): _____

Authorization:

I, the undersigned, authorize KidsWatch Pediatrics & Urgent Care to release my/my child's (if applicable) medical records to:

- **Recipient Name:** _____
- **Recipient Address:** _____
- **Recipient Phone Number:** _____
- **Recipient Email Address (Optional):** _____

Purpose of Release (Check all that apply):

- ☐ Continuing Medical Care
- ☐ Consultation with Another Physician
- ☐ Insurance Purposes
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other (Please specify): _____

Information to be Released (Check all that apply):

- ☐ Entire Medical Record
- ☐ Specific Dates of Treatment: From _____ To _____
- ☐ Admission/Discharge Summaries
- ☐ Lab Results
- ☐ X-ray/Imaging Reports
- ☐ Consultation Reports
- ☐ Immunization Records
- ☐ Medication List

KidsWatch Pediatrics & Urgent Care
(P) 703-775-0777 (F) 703-589-9699
www.kidswatchpedaitrics.com
7263-F Arlington Blvd, Falls Church, VA 22042

- ☐ Problem List/Diagnoses
- ☐ Other (Please specify):

  _____

Method of Release (Check all that apply):

- ☐ Mail
- ☐ Email (Please be aware that email communication may not be secure)
- ☐ Fax: _____
- ☐ Pick-up (Requires valid photo ID)

Expiration of Authorization:

This authorization will expire on (date)_____or upon revocation by the patient/legal representative, whichever occurs first.

Right to Revoke:

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken[1] based on it. My revocation must be sent to KidsWatch Pediatrics & Urgent Care at the address listed below.

Right to Inspect and Copy:

I understand that I have the right to inspect or copy the medical information to be disclosed under this authorization.

Redisclosure:

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected[2] by HIPAA.

Signature:

- Patient/Legal Representative Signature: _____
- Printed Name: _____
- Relationship to Patient (if not the patient): _____
- Date: _____

Contact Information of Healthcare Provider/Facility Releasing Records:

- Name: _____
- Address: _____
- Phone Number: _____

Please return this form to:

KidsWatch Pediatrics & Urgent Care, 7263 Arlington Blvd, Suite F, Falls Church, VA 22042

Important Notes:

- Please allow sufficient time for processing your request.
- A fee may be charged for copying medical records.
- This form is for the release of medical information *from* the named healthcare provider/facility *to* the named recipient. If you need records *from* another provider, you will need a separate authorization form for that entity.