CHILDREN'S MEDICAL
ASSOCIATES OF
NORTHERN VIRGINIA, P.C.
6303 Little River Turnpike, #300
Alexandria, Virginia 22312
(703) 914-8989
Fax (703) 914-5494

RECORD RELEASE

CHILDREN'S MEDICAL
ASSOCIATES OF
NORTHERN VIRGINIA, P.C.
10615 Braddock Road, #200
Fairfax, Virginia 22032
(703) 691-4700
Fax (703) 691-4791

Child's First Name	Child's Last Name	Middle Initial	Date of Birth mm/dd/yyyy	Sex M/F

Current Home Address & Phone Number _____

_____

_____

New Home Address_____

_____

_____

I authorize Children's Medical Associates of Northern Virginia to **release** information **TO**:	
❑ Parent (Recommended), ❑ Patient (If 18 yrs or older) or ❑ Provider/Facility (Not Recommended - Please call our office)	
Address:	
Phone:	Fax:

PURPOSE OF THIS REQUEST (Must check one): ❑ Relocation ❑ Change In Insurance
❑ Leaving Practice/New Doctor ❑ Other: _____

RECORDS REQUESTED:

❑ Immunizations (Free)	All Records from October 8, 2013 to present. (Electronic Health records) — ❑ Secure link email $6.50 _____ (email address) ❑ Hard copy (Paper) $20.00 + $0.37/page for pages 1 - 50, $0.18/page thereafter.
❑ Last Physical Exam, Immunization Record, and Growth Chart (most common) — $15	❑ All Record PRIOR to October 8, 2013 (Health records in paper charts) — $20.00 + $0.50/page for pages 1 - 50, $0.25/page thereafter.

❑ I do ❑ I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessments, and treatment for alcohol and/or drug abuse.

I understand that:

- This authorization is valid for 12 months from the date of signature
- I may cancel this authorization at anytime by submitting a written notification but that it will not affect any information release prior to notification of cancellations.
- If the person or facility receiving this information is not a health care of medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Virginia Law permits a charge for personal copy/transfer of your records. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

Signature of Patient (If 18 yrs or older):_____ Date: _____

Signature of Parent/Legal Guardian (If under 18 yrs):_____ Date: _____