AAA PEDIATRICS
2200 Opitz Blvd. Suite 355
Woodbridge, VA 22191
(703) 580-6400

AAA Pediatrics

email: info@aaapeds.com
Fax: (703) 580-4550

RECORD RELEASE

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

Current Home Address & Phone #: _____

New Home Address: _____

I authorize AAA PEDIATRICS to **release** information TO:	**OR**	I authorize AAA PEDIATRICS to **obtain** information FROM:
Name of Provider/Facility:		**Name of Provider/Facility:**
Address:		**Address:**
Phone:		**Phone:**
Fax:		**Fax:**

PURPOSE OF THIS REQUEST (Must check one): ☐ Relocation ☐ Insurance Coverage
☐ Leaving Practice/New Doctor ☐ Other: _____

RECORDS REQUESTED:

[ ] Summary/Immunizations/Last Sick&Well (most common) $15 (P2P free, electronic only)		**[ ] ENTIRE Medical Record ($15 + Additional Fee based on chart quantity) (P2P free, electronic only)**	
☐ Immunizations (free)	**☐ Lab Reports**	**☐ X-Ray Reports**	**☐ Other:**

☐ I do ☐ I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment, 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 any time by submitting a written notification but that it will not affect any information release prior to notification of cancellation.
- 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:** _____