CHANCELLOR PEDIATRICS

12004 Kilarney Drive Fredericksburg, VA 22407

Phone (540) 548-4510 Fax (540) 548-4513

AUTHORIZATION FOR RELEASE OR OBTAIN MEDICAL RECORDS

PATIENT'S NAME (PLEASE PRINT) _____

PATIENT'S ADDRESS _____**DATE OF BIRTH**_____

PERSON REQUESTING_____ **CONTACT P#**_____

REASON FOR REQUEST_____

I REQUEST THAT MEDICAL RECORDS BE RELEASED:

FROM: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

TO: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

PLEASE UNDERSTAND PREVIOUS MEDICAL RECORDS AND/OR CONSULTS FROM OTHER PHYSICIANS WILL NOT BE INCLUDED WITH THIS TRANSFER. THOSE RECORDS MUST BE OBTAINED FROM THEIR OFFICE(S).

EXTENT OF INFORMATION TO BE RELEASED: COMPLETE RECORD _____ SPECIFIC DATES _____

__I DO __ I DO NOT AUTHORIZE RELEASE OF INFORMATION RELATED TO AIDS OR HIV INFECTION, PSYCIATRIC CARE AND /OR PSYCHOLOGICAL ASSESSMENT AND TREATMENT FOR ALCOHOL, AND/OR DRUG ABUSE.

I UNDERSTAND THAT THERE MAY BE A COPYING OF FEE FOR RECORDS IF OBTAINED FOR PERSONAL USE PROVIDED BY CHANCELLOR PEDIATRICS IS AS FOLLOWS: $0.50 PER PAGE FOR THE FIRST 50 PAGES AND $0.25 PER PAGE FOR EACH ADDITIONAL PAGE COPIED. PAYMENT FOR THE RECORDS AND ANYOUTSTANDING BALANCE ON YOUR ACCOUNT MUST BE PAIN IN FULL PRIOR TO RECORDS BEING PROCESSED. **I UNDERSTAND THAT I HAVE THE RIGHT TO ACCESS MY MEDICAL REORDS IN ACCORDANCE WITH THE LAW AND THE POLICIES OF CHANCELLOR PEDIATRICS. I HEREBY AUTHORIZE DISCLOSURE OF THE DATE OF SIGNATURE. I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED MY BE SUBJECT TO RE-DISCLOSURE BY THE PERSON OR CLASS OF PERSONS OR FACILITY RECEIVING IT, AND COULD THEN NO LONGER BE PROTECTED BY FEDERAL REGULATION. I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS IS FURNISHED MAY NOT CONDITION TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION.

SIGNATURE_____ **DATE**_____