Pathways
Developmental Pediatrics
Personalized care for individual minds

Authorization to Release Medical Records

Date: _____

Patient Name: _____ **DOB:** _____

This Authorizes _____PATHWAYS DEVELOPMENTAL PEDIATRICS_____ to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- ❑ Complete record
- ❑ Records of care from the following dates: _____ to _____
- ❑ Records concerning the following conditions: _____
- ❑ Other, please specify:

_____

The reasons or purposes for this release of information are as follows:

_____

_____

Release to the following person(s):

Name:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Expiration Date: _____ or **Expiration Event** as detailed below:

- I understand that ___PATHWAYS DEVELOPMENTAL PEDAITRICS_____ will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying __PATHWAYS DEVELOPMENTAL PEDIATRICS____ in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- I agree to be responsible for and pay the fee for providing copies of my medical information.

_____

Parent/Guardian Name **Signature** **Date**

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