



21 Highland Avenue, Suite 100 • Roanoke, VA 24013 Telephone (540) 344.9213 • Facsimile (540) 345.7559

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I am authorizing to be disclosed may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

Patient's name: _____ Date of Birth: _____

Persons/organizations providing information: _____

Persons/organizations receiving information: _____

Specific description of information (including date(s)): _____

Purpose of the use or disclosure: _____

The patient, or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _____

b. I understand that I get a copy of this form after I sign it.
Initials: _____

c. I understand that this authorization will expire on ____/____/____, or upon the event of _____
Initials: _____

d. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Physicians to Children in writing, but if I do, it won't have any effect on actions Physicians to Children took before I received the revocation.
Initials: _____

e. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is \$.50 per page up to 50 pages, \$.25 per page 51 pages and up.

Signature of patient or representative: _____ Date _____

Printed name of patient's representative: _____

Relationship to the patient: _____