REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of the following medical records:

First, Middle initial, Last name: Date of birth:

1. ____ ________________

2. ____ ________________

3. ____ ________________

From/To:

Renaissance Pediatrics, PC
4012 Raintree Road, Suite 200-A
Chesapeake, VA 23321
Ph (757)488-2223 Fax (757)488-8398

From/To: Name: ____

Mail/Pick up Street Address: ____

City/State/Zip code: ____

Phone Number (please include area code): _____________________________

Please allow 2 weeks from receipt of signed request for processing. Thank you.
****EXPIRES 3 MONTHS FROM DATE SIGNED****

REQUIRED: You must describe what is to be disclosed AND the reason for the disclosure.

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~I understand that I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
~I understand that the information released in response to this authorization may be re-disclosed to other parties.
~I understand that treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____________________________________ _____________________ ___/___/___
Signature* Relationship to patient Date

**IF PATIENT IS 18 YRS OR OLDER, PATIENT MUST SIGN.*

Witnessed by (initials) ______

Confidentiality Note:
These medical records contain legally privileged and confidential information intended only for the use of the individual or entity named above. If the recipient of these records is not the intended recipient, you are hereby notified that any dissemination, distribution, or reproduction of these records is strictly prohibited. If you have received these records in error, please notify us immediately by telephone. ~ Thank you ~