Authorization for Release of Medical Information

Patient Name: _____DOB: _____/_____/_____
By my signature below, I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
Please release these records **TO**:

Firefly Pediatrics
2820 Waterford Lake Dr. Ste 102 Midlothian, VA 23112
Phone: 804-372-3473 Fax: 804-322-5201

FROM: Doctor/Clinic/Hospital:_____

Street: _____ City:_____ State: _____ Zip: _____

Phone:_____ Fax: _____

By my signature below, I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Please release the following:

____ **All health information (including growth charts and vaccination records)**

____ History/Physical Exam
____ Progress Notes
____ Vaccination Records
____ Growth Charts
____ Diagnostic Test Reports and Radiology/Images
____ Discharge Summaries
____ Lab Results and Pathology Reports
____ Consultation Reports
____Other (specify): _____

____ By initialing here, I do NOT consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug use disorders, with the rest of the medical records

Purpose of disclosure:
____ Treatment/ Continuing medical care
____ Other, please specify: _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall expire in 12 months. If I am responsible for payment of a fee for preparing and furnishing this information, I acknowledge that responsibility. Charges will comply with the Virginia Statutory Code.

Signature: _____ Date: _____/_____/_____

Print Name: _____ Relationship to Patient: _____