Village Center Pediatrics

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REQUEST FOR MEDICAL RECORDS

I,_____ hereby authorize your facility to release any information, including the diagnosis, prognosis, treatment, and any pertinent information related to my child's healthcare for all dates of service with your practice from Dr. Tammy Maschino, Dr. Kimberly Edgmon, Dr. Susan White, Dr. Jessica Yocum and Lauren Adams, APRN.

Please release records for the following children: **Date of Birth:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Send Records To: (Please choose delivery option)

- ○ Mail
- ○ Email
- ○ Fax
- ○ Pick Up

Request Reason: (Please select reason for admin purposes)

- ○ Moving _____ (date)
- ○ Transfer of Care
- ○ Specialist
- ○ Other

Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

I understand:

- I may void this authorization at any time, in writing. My void will not apply to information already retained, used or disclosed in response to this authorization.
- Unless the purpose of the authorization is to determine payment of claim or benefits, Village Center Pediatrics, LLC may not use this as a cause of change in the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.
- The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

Date: _____ **Signature:** _____
Parent or Legal Guardian or Patient if over 18

Processed & Documented By: _____
Date