Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

PROTECTED HEALTH INFORMATION AUTHORIZATION TO DISCLOSE/RELEASE

Date:

I authorize the medical practice and administrative staff of Boulevard Center Pediatrics, Inc. to RELEASE the medical records of:

Patient Name: **Date of Birth:**

_____ _____

_____ _____

_____ _____

_____ _____

Address of Patient:

Telephone Number:

TO: the following individual or entity

Name:_____

Address:_____

Tel. No.:_____ Fax No.:_____

Information to Be Released:
□Immunization Record □Last Physical Exam □Lab Results □Specialist Notes □Other_____

For the following Purpose:
□Changing Physician □Moving Away □School □IRS □Work □Daycare □Other_____

My signature below reflects that I understand that this authorization shall be in force and effect for 30 days or until the expiration date specified below if indicated. I further understand that sensitive information, such as but not limited to: drug use, alcohol use, mental health history or treatment, or other confidential and protected health information, may be a part of the medical record and will be included in the above release. I further understand that I have the right to revoke this authorization at any time by sending written notification to: **Privacy Officer, Boulevard Center Pediatrics, Inc., 3733 Fettler Park Dr. Dumfries, VA 22025.** I also understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The office of Boulevard Center Pediatrics, Inc. is not responsible for re-disclosure by the intended recipient.
I understand that Boulevard Center Pediatrics, Inc. will not make my treatment, payment, enrollment in a health plan or eligibility for benefits conditioned on providing this authorization, except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
Fees: All fees are payable in advance. Medical Records: $15 for Medical Summary, $20 for Full Records (including forms filled out in office during visits), Copies $1 Fees are subject to change and some requests may incur an additional charge for printing and/or mailing fees.

Name of Parent/Guardian_____ Tel. No._____

Signature_____ Expiration Date of Authorization_____