

CHILDREN'S MEDICAL ASSOCIATES OF NORTHERN VIRGINIA, P.C.
 6303 Little River Turnpike, #300
 Alexandria, Virginia 22312
 (703) 914-8989
 Fax (703) 914-5494
 email: forms.alex@cmanva.com



CHILDREN'S MEDICAL ASSOCIATES OF NORTHERN VIRGINIA, P.C.
 10615 Braddock Road, #200
 Fairfax, Virginia 22032
 (703) 691-4700
 Fax (703) 691-4791
 email: forms.ffx@cmanva.com

Child's First Name	Child's Last Name	Middle Initial	Date of Birth mm/dd/yyyy	Sex M/F

Current Home Address & Phone Number _____

New Home Address _____

I authorize Children's Medical Associates of Northern Virginia to **release** information **TO**:

Parent (Recommended), Patient (If 18 yrs or older) or Provider/Facility (Not Recommended - Please call our office)

PURPOSE OF THIS REQUEST (Must check one): Relocation Change In Insurance
 Leaving Practice/New Doctor Other: _____

RECORDS REQUESTED: ONLY CHECK ONE BOX and provide needed information within section.

All Records **from October 8, 2013 to present.** (Electronic Health records) —
 Secure link email \$6.50 — **Parent's email address:** _____

Only last Physical Exam, Immunization Record, and Growth Chart (*Faxed or mailed only. Fill out information below.*) — \$15

All Records **from October 8, 2013 to present.** (Electronic Health records) —
 Hard copy (Paper) \$20.00 + \$0.37/page for pages 1 - 50, \$0.18/page thereafter (*Pick up or mail only. Fill out information below.*)

All Records **PRIOR to October 8, 2013** (Health records in paper charts) —
 Hard copy (Paper) \$20.00 + \$0.50/page for pages 1 - 50, \$0.25/page thereafter. (*Pick up or mail only. Fill out information below.*)

Address to release records to: _____

Phone: _____ Fax: _____

I do I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessments, and treatment for alcohol and/or drug abuse.

I understand that:

- Processing may take up to 10 business days.
- This authorization is valid for 12 months from the date of signature
- I may cancel this authorization at anytime by submitting a written notification but that it will not affect any information release prior to notification of cancellations.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Virginia Law permits a charge for personal copy/transfer of your records. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

Signature of Patient (If 18 yrs or older): _____ Date: _____

Signature of Parent/Legal Guardian (If under 18 yrs): _____ Date: _____

(Must be signed with pen, no electronic signature accepted.)