AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Authorization:
I hereby authorize:

PEDIATRIC ASSOCIATES OF WINCHESTER
1002 AMHERST STREET
BUILDING C
WINCHESTER, VA 22601
PHONE: (540) 662-3853
FAX: (540) 662-0336

AND _____
NAME

_____
ADDRESS

_____
CITY **STATE** **ZIP**

To release and share information regarding my medical and psychosocial history, immunizations, illness and or injury

INFORMATION TO BE RELEASED:

- ☐ **Hospital**
- ☐ **Consultation**
- ☐ **Labs**
- ☐ **Immunizations/Recent Physical**
- ☐ **Progress Notes**
- ☐ **X-Rays**
- ☐ **ALL RECORDS**
- ☐ **Other**

THE PURPOSE FOR DISCLOSURE:

- ☐ **Moved**
- ☐ **Specialist/Coordination of Care**
- ☐ **Change Doctor**
- ☐ **Insurance**
- ☐ **Personal**
- ☐ **Other** **Please Specify:**_____

**** charges may apply for reason other than transfer of care (0.50 cents for the first 50 pages and 0.25 cents for each page after)***

This authorization is good from _____ to _____.

_____
SIGNATURE OF PATIENT/LEGAL GUARDIAN

_____
PATIENT NAME/DATE OF BIRTH

_____
ADDITIONAL PATIENT NAMES

_____
PHONE NUMBER

_____
ADDRESS