Mountain Ridge Pediatrics

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PURPOSE OF RELEASE: ______________________________

Please read all information and instructions before completing and signing this authorization form.

Child's First Name:	Child's Last Name:	Date of Birth:
		/ /

Information to be Released by:	Information to be Released to:
Mountain Ridge Pediatrics **2034 Pro Pointe Lane** **Harrisonburg, Virginia 22801** **Phone: 540-217-5333** **Fax: 540-217-5328**	______________________ Organization/Person Name ______________________ Address ______________________ City State Zip ______________________ Phone Number ______________________ Fax Number

Type of Information Requested:	Dates Associated with Information:
□ Complete Medical Record	
□History & Physical (admission)	
□Discharge Summary	
□Consultations	
□Clinical Summary	
□Lab/Radiology Reports	
□Diagnostic Reports	
□Billing Records	
□Immunization Records	
□Prescriptions	

This authorization will expire on __________ or 90 days from the set forth date below.

I hereby consent to the release of the specified information relating to diagnosis, testing, and/or treatment to the person(s) or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge that I have fully reviewed and understand the contents of this authorization form. I understand that authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), Psychiatric Care, Behavioral and/or Mental Health services, Treatment for alcohol and/or drug abuse, and/or genetic testing. My signature below indicates that I hereby agree to and authorize the release of patient information to Mountain Ridge Pediatrics. I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility of benefits).

______________________ ______________________ ______________
Circle: Patient or Parent/Guardian Print Signature Date

______________________ ______________________ ______________
Witness Print Signature Date

PATIENTS 18 YEARS OR OLDER MUST SIGN FOR AUTHORIZATION