

PENGUIN PEDIATRICS 44081 PIPELINE PLAZA #125 ASHBURN, VA 20147
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number

(City, state, zip code)

Phone (Home)

(Parent/Guardian if Patient < 18 yrs)

Chart #

At the request of the individual, I _____, do hereby authorize PENGUIN PEDIATRIC to release:
(Patients Name) (Name of Facility)

SERVICE DATES OF _____

WELL CHILD VISITS _____ PATHOLOGY REPORTS _____ IMMUNIZATIONS ONLY

SICK CHILD VISITS _____ LABORATORY REPORTS _____ ENTIRE CHART

ALL OFFICE VISITS _____ RADIOLOGY REPORTS _____ LAST 3 YEARS

OPERATIVE NOTES _____ ECG/EEG/CARDIO CATH _____ OTHER _____

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ LEAVING PRACTICE
____ LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL _____ RELOCATION/MOVING
OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS. VA RATES pgs 1-50 are \$0.50 each, pgs 51+ are \$0.25 each plus postage and handling. HEALTHPORT DOES NOT FAX RECORDS, ALL RECORDS ARE MAILED

Signature of individual or guardian or
Personal Representative of patient's estate Power of Attorney Must Be Attached

Date

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-Ray _____ OTHER _____
HP _____ PATH _____

ROI SPECIALIST

DATE