Request for Medical Record Transfer

If any sections are incomplete, this form may be invalid

Release information:

☐ To

☐ From

PediatriCare of Northern VA
8640 Sudley Rd., Ste 306
Manassas, VA 20110
Ph: (703)330-3939
Fax: ☐ (703)331-0959 (Manassas)
☐ (703)754-1561 (Haymarket)

Release information:

☐ To

☐ From

Name of Person or Facility: _____
Address: _____
City:_____ State:_____ Zip:_____
Ph:_____
Fax:_____

☐ To Send Electronically via e-mail address:

_____

Purpose of Copying Records: ☐ Transfer to another Pediatric Practice ☐ Transfer to Adult Practice
☐ Visit to a Specialist ☐ Attorney Use ☐ Personal ☐ Other(describe):_____

Type of Records Requested:

- ☐ Vaccine Record Only
- ☐ Complete Medical Records
- ☐ Last 2 years (Please note that as a standard, this facility will send the last 2 years of office notes, labs, and immunization records)
- ☐ Specific Dates: _____
- ☐ Other: _____

SENSITIVE INFORMATION RELEASE: I authorize the release of information related to STD's, AIDS or HIV, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

☐ Yes or ☐ No

Patient's (Legal) Name	**Date of Birth**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms of this document.

- This authorization is valid for 12 months from the date of signature.
- I may cancel this authorization at any time by submitting a written notification but that will not affect any information released prior to notification cancellation.
- If the person or facility receiving this information is not a health care or medical provider covered by privacy regulations, the information stated above could be re-disclosed by the recipient and no longer protected by federal or state law.
- I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from HealthPort Technologies.

Signature: _____ **Date**: _____

Printed Name: _____ Relationship:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Record Copying Fees

- The state of Virginia allows a fee to be associated with medical record request processing. CIOX Health has been contracted by our facility to provide this service and will invoice you directly.
- Please don't hesitate to call **(800) 367-1500** if you have any questions about the services CIOX Health provides on our facilities behalf, or about the bill you may receive as a result of your request for medical records.