Pediatric Associates of Alexandria

HealthPlex Office
6355 Walker Lane, Suite 401
Alexandria, VA 22310

Potomac Yard Office
3600 S. Glebe Rd. Suite 150
Arlington, VA 22202

Duke Street Office
2747 Duke Street
Alexandria, VA 22314

Tel: (703) 924-2100
Fax: (703) 922-6067
Email: staff@pedsalex.com

www.pedsalex.com
www.healthychildren.org

Immunization Records Release Form

Authorization for the Release of Protected Health Information

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

****PATIENT 18 YEARS OF AGE ARE CONSIDERED ADULTS AND THEREFORE MUST REQUEST THEIR OWN M RECORDS*****

Name: ___________________________________ **DOB:** ____/____/____

Name: ___________________________________ **DOB:** ____/____/____

Name: ___________________________________ **DOB:** ____/____/____

Fax Information To:
Healthplex Office:
6355 Walker Lane Suite 401
Alexandria, VA 22310
OR
Potomac Yard Office
3600 S. Glebe Rd. Suite 150
Arlington, VA 22202
Phone: 703-924-2100 ext.249 Fax: 703-922-6067

Requesting Information:
Name:___________________________
Address:_________________________
City, States, Zip:___________________
Phone:___________________________
Fax:____________________________

Specific Description of the Information to be Disclosed:

❒ **I would like my child's immunization records faxed.**

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. I understand that I have the right to refuse to sign this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office to the attention of the Privacy Officer. Absent such written revocation, this *Authorization Form for Release of Protected Health Information* will expire in 2-years from the date initiated below.

____ ____________
Signature of Parent, Patient or Guardian *Date*

____ ____________ ______________
Printed Name of Parent, Patient or Guardian *Relationship* *Phone Number*

Updated: 12/16