NOVA
PEDIATRICS, LTD.

AUTHORIZATION FOR NOVA TO RECEIVE PROTECTED HEALTH INFORMATION

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB _____

Please check the item that pertains to your request:

- ❒ Immunization Records
- ❒ Last Physical Exam
- ❒ State / County Physical Form
- ❒ Medical Records
- ❒ Other (Please Specify) _____

Reason for Request of PHI (release of records)_____

PHI Released To:

NOVA Pediatrics
6120 Brandon Ave. #308
Springfield, VA 22150
Phone (703)451-3333 Fax (703)451-7219

PHI Receiving From:

_____
_____
Phone #:_____
Fax #:_____

_____
Signature of Patient or Legal Guardian

_____
Relationship to Patient

_____
Print Name of Patient or Legal Guardian

_____
Date

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Nova Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Nova Pediatric's Privacy Officer at 6120 Brandon Avenue, Springfield, VA 22150.

OFFICE USE ONLY:

Date Request Sent: _____ Initials: _____
Date Received: _____ Initials: _____