AUTHORIZATION FOR NOVA TO RELEASE PROTECTED HEALTH INFORMATION

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:

Name____

Address: ____

Phone ( ) ____________________________ Fax ( ) ____________________________

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies, labor, and postage related to the production of my information. I understand that the charge for this service is $0.50 per page for the first 50 pages; $0.25 per page for each additional page plus a $10.00 processing fee.

______________________________ ______________________________
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 Pediatrics' Privacy Officer at 6120 Brandon Avenue, Springfield, VA 22150.

OFFICE USE ONLY:

Pick-Up Date ____________________ Metered Date ____________________
Amount Paid $ ____________________ Doctor's Initial ____________________

Fax back to: 703.451.7219