



**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

**Please check the item that pertains to your request:**

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

Reason for Request of PHI \_\_\_\_\_

**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 \$\_\_\_\_\_ plus certified mailing charges if applicable.

\_\_\_\_\_  
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:**

Pick-Up Date \_\_\_\_\_ Metered Date \_\_\_\_\_

Amount Paid \$ \_\_\_\_\_ Doctor's Initial \_\_\_\_\_