13135 Lee Jackson Memorial Hwy, Suite 201
Fairfax, VA 22033
Ph: 703-391-0900
Fax: 703-391-2919

REQUEST AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I request and authorize the release, use, and/or disclosure of the below named individuals' health information as described below to Fairfax Pediatric Associates, P.C. for the purpose of further medical care.

Please: ☐ mail the requested information to FPA at the address above
☐ I authorize the "fax" of the requested information to the "fax" number above.

☐ Summary Paper Copy to include Immunization Record, Growth Chart, and Summary Medical History
☐ Complete Medical Record
☐ Specify Other:_____

For patients:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Patient Address:_____

Patient Telephone No_____ MED. REC. NO.:_____

The following individual or organization is authorized to make the disclosure to Fairfax Pediatric Associates, P.C.

_____
name of individual or organization

_____
address

_____
city/state/zip

_____ _____
phone number fax number

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to FPA's Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization **will expire automatically six (6) months from the date on which it was signed**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact FPA's Privacy Official.

_____ _____
Signature of Patient/Parent/Authorized Representative Date

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (45 CFR, PART 164) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO WRONGFULLY USES OR DISCLOSES HEALTH INFORMATION MAY BE FINED $5000.00 TO $250,000.00, AND/OR MAY BE IMPRISONED FOR ONE TO TEN YEARS.