



Medical Records Release Form

Authorization for the request of Protected Health Information

There will be a fee for the requested records. Please allow a minimum of 1-2 weeks for processing.

- Please be aware that medical records can be obtained through the patient portal app **free** of charge.

To access Patient Portal Records: Login to the patient portal app – Click on “My Records”- Appointments- Then Click on each appointment and at the bottom click on Download PDF.

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.

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Please circle TO/FROM appropriately to avoid delays in record processing

TO / FROM:

Pediatric Associates of Alexandria

- 6355 Walker Lane
Suite 401
Alexandria, VA. 22310

- 3600 S Glebe Rd
Suite 150
Arlington, VA. 22202

Phone: 703.924.2100

Fax: 703.922.6067

TO / FROM:

Address: _____

Phone: _____

Fax: _____

- All Medical Records Immunization Records Only Specific dates of service, from: ____/____/____ to ____/____/____

If Pediatric Associates of Alexandria is releasing your child(ren)s' medical records to you or to another party such fees are associated. Please allow a minimum or 1-2 weeks for processing.

All Records-Fee: \$0.50 per page for the first 50 pages; \$0.25 a page for each additional page plus a 10.00 handling/mailing fee.

- Digital Copy of records (\$25.00 for first record. \$15.00 dollars per additional sibling. Postage included in price)

Signature of Parent, Patient or Guardian

Date

Phone Number

Printed Name of Parent, Patient or Guardian

Relationship