Virginia Pediatric Eye Center

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____Telephone #: _____

I hereby agree and **authorize** _____ to disclose protected health information **to**:
Health Care Facility or Physician Name

Virginia Pediatric Eye Center
Health Care Facility or Physician Name

Telephone # (757) 461-0050 Fax # (757) 461-4538

Purpose of Request:
☐ Continued Care ☐ Personal ☐ Attorney/Legal ☐ Insurance ☐ Disability ☐ Other: _____

Records Requested:
☐ Physician/Office Notes ☐ Operative/Surgical Notes ☐ Other (be specific): _____

I understand that I may revoke this authorization at any time by giving written notice except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Virginia Pediatric Eye Center.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

This authorization expires _____

Print Name of Patient: Patient's Date of Birth:

_____

Signature of Parent or Personal Representative:* Date:

_____

Print Name Parent or Personal Representative:*

_____

* If an authorization is signed by an individual's Personal Representative, the representative's authority is based on:
_____ (e.g. state law, court order, etc.)

Code of Virginia 8.01.413: Fees for records:
Search and handling fee up to $20 plus $0.50 per printed page (1-50 pages) plus $0.25 per printed page (over 50 pages)
OR $0.37 per digital page (1-50 pages) plus $0.18 per digital page (over 50 pages)