



PL Pediatrics, PLLC
 Dr. Pamela Mancini
 Dr. Nimali Fernando

321 Park Hill Drive
 Fredericksburg, VA 22401
 P. (540)361-1800 F.(540)361-1803

Authorization for Release of Medical Information

Patient's Name: _____ DOB: _____
 Address: _____
 City/State/Zip Code: _____
 Phone: _____
 Date of Request: _____

<input type="checkbox"/> I authorize PL Pediatrics, PLLC to release information to:
Name of Provider or Practice
Address
City/State/Zip
Phone & Fax

OR

<input type="checkbox"/> I authorize PL Pediatrics, PLLC to obtain information from:
Name of Provider or Practice
Address
City/State/Zip
Phone & Fax

Purpose for request (check one):

- Transfer of care
 Insurance Coverage
 Other

Type of Records Requested (check one):

- Immunization history
- All medical records related to a specific injury or illness (list below):

- Treatment summary (Includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
- Specific information (list below):

- Copy of entire medical record, as allowed by law.

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release P.L. Pediatrics, PLLC. from, and covenant not to sue P.L. Pediatrics, PLLC. for any claim that I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy information used/disclosed under this authorization. I understand that I may revoke this consent to release information at anytime, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire six months after the date specified below, or on the date, event or condition described as:

Virginia law allows for copy charges consisting of the following: \$10.00 administrative fee PLUS \$0.50 per page for the first 50 pages and \$0.25 per page thereafter, and \$1.00 per page of microfilm/fiche.

Parent/ Guardian Signature: _____ Date: _____
 Relationship to Patient: _____ Date: _____
 Witness Signature: _____ Date: _____