FROM *(location indicated by check mark)*

☐ 321 Main Street
Newport News, VA 23601
Phone: (757) 595-0358
Fax: (757) 595-6745

☐ 716 Denbigh Blvd., A-2
Newport News, VA 23608
Phone: (757) 874-7070
Fax: (757) 989-0955

☐ 3055 Geo. Washington Mem. Hwy.
Hayes, VA 23072
Phone: (804) 642-9231
Fax: (804) 684-2461

CHILDREN'S CLINIC, LTD

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name: **DOB:**

_____ _____

Person, Agency, or Health Care Entity **FROM** which information is requested:

_____

Address: _____

Telephone # _____ Fax # _____

Person, Agency, or Health Care Entity **TO** whom information will be sent:

_____

Address: _____

Telephone # _____ Fax # _____

Information/Health Records to be disclosed: _____

Purpose of Disclosure or at the Request of the Individual: _____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such condition is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity. We operate/function in compliance with Federal HIPAA and HITECH rules.

Signature of Individual or Legal Representative: _____

Print Name: _____ Date of Signature: _____

Relationship or Authority of Legal Representative: _____

This authorization expires on: _____ (if left blank, expires one year from date of signature)