

**PEDIATRIC ASSOCIATES OF RICHMOND, INC.**  
**Patient Authorization for Use/Disclosure of Health Care Information**

\*\* Provide the patient with a copy of the signed form. \*\*

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

I request and authorize Pediatric Associates of Richmond, Inc. to release health care information of the patient named above to:

**Name:** \_\_\_\_\_  
(Name of individual or entity to receive the information)

**Address:** \_\_\_\_\_

**City, State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Fax # if applicable** \_\_\_\_\_

This authorization form applies to the following information (be specific):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc. List specific purposes here. Please write "at the request of the individual" when the disclosure is requested by the patient or parent / legal guardian.]

This protected health information is being used or disclosed for the following purposes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THIS AUTHORIZATION EXPIRES ON \_\_\_\_\_  
(Date)

OR WHEN THE FOLLOWING EVENT OCCURS:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Pediatric Associates of Richmond, Inc. has relied on my authorization. I understand that to revoke this authorization, written notification must be sent to:

Privacy Officer, Pediatric Associates of Richmond, Inc., 7113 Three Chopt Road #101, Richmond, Va. 23226

I understand that once this information is released by Pediatric Associates of Richmond, Inc., the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

\_\_\_\_\_  
**Printed Name of Parent / Legal Guardian**

\_\_\_\_\_  
**Signature of Parent / Legal Guardian** **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_