Northern Virginia Pediatric Associates, P.C.

107 North Virginia Ave, Falls Church, VA 22046
Phone: (703) 532-4446 | Fax: (703) 532-8426

I AUTHORIZE _____

Name of Sending Physician, Agency or Institution

_____

Address

_____

City / State / Zip

_____

Phone # Fax #

TO RELEASE TO **Northern Virginia Pediatric Associates, P.C.**
107 North Virginia Avenue
Falls Church, VA 22046

The Following Information: (Information to be released must be clearly specified)

_____

In Regard To:

1. _____ Date Of Birth _____
   Child's Name at Time of Treatment
2. _____ Date Of Birth _____
   Child's Name at Time of Treatment
3. _____ Date Of Birth _____
   Child's Name at Time of Treatment
4. _____ Date Of Birth _____
   Child's Name at Time of Treatment

_____

Signature of Patient or Responsible Person **Date**

If This Release Pertains To Alcohol or Drug Abuse Information, Please Note That:
This Information Has Been Disclosed To You From Records Whose Confidentiality is Protected by Federal Law. Federal Regulation (42 C.F.R. Part 2) Prohibits You From Making Further Disclosure Of It Without The Specific Written Consent Of The Patient To Whom It Pertains, Or As Otherwise Permitted By Such Regulations. A General Authorization For The Release Of Medical Or Other Information Is Not Sufficient For This Purpose.