**Northern Virginia Pediatric Associates, P.C.**
107 North Virginia Ave, Falls Church, VA 22046
Phone: (703) 532-4446 | Fax: (703) 532-8426

**Authorization To Release/Disclose Protected Health Information Form**

Patient's Name: _____

Date of Birth: _____

Phone Number: _____ Cell: _____

I authorize: _____ Dr. _____ to release or disclose information

To: _____

Address: _____

_____

Phone: _____ Fax: _____

**Information to be Released/Disclosed**

☐ Consultation
☐ Progress Notes
☐ Plan of Care
☐ Other: _____

**Purpose :**

☐ Continuity of Care

I understand that if the person or agency that received my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand Northern Virginia Pediatric Associates, P.C. may not condition treatment on my decision to sign this authorization. I understand that this disclosure may include information regarding my child/children medical health and/or mental condition.

**This authorization expires _____ days after signing authorization.**

_____ _____

**Signature of Patient or Representative** **Date**