Children's Health Care Center of Northern Virginia
9001 Digges Road, Suite 106
Manassas VA, 20110
(Phone) 703-392-5437 (Fax) 703-392-0176

Protected Health Information Authorization Form

☐ I authorize Children Health Care Center to release information to:	OR	☐ I authorize Children Health Care Center to obtain information from:
Name of Provider or Facility:		Name of Provider or Facility:
Address:		Address:
City, State, Zip		City, State, Zip
Phone/ Fax #		Phone/ Fax #

I REQUEST:

___ Complete Medical Records ___ Immunization Records ONLY

___ Labs & X-rays ___ Other: _____

PATIENT'S NAME(S):

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

PARENT'S/LEGALGUARDIAN NAME _____

ADDRESS _____

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

Brief reason for transfer: _____

_____ **(Parents/Legal Guardian Initials)** I understand there is a **$30.00 Medical Records fee** for **EACH** chart copied or mailed. There is **NO fee** for Immunization Records ONLY. I am also aware this authorization is valid only from the date of signature**.**

The PHI (protected Health Information) contained in this Form/ Fax is HIGHLY CONFIDENTAIL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPAA) and will reported as such.