

Authorization for Release of Medical Information

Patient Name: \_\_\_\_\_ DOB: \_\_ / \_\_ / \_\_

I, \_\_\_\_\_ hereby authorize the release of medical information

TO: Alethea Allen, M.D., F.A.A.P  
Grace Point Pediatrics  
480 W. Jubal Early Drive, Suite 320  
Winchester, VA 22601  
phone 540-486-4138 fax: 540-773-5757

FROM:  
Doctor/Clinic/Hospital: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_

Please release the following:  
 **All health information (including growth charts and vaccination records)**

- |   |  |
|---|--|
| <input type="checkbox"/> History/Physical Exam  | <input type="checkbox"/> Diagnostic Test Reports |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Radiology/Images        |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Lab Results             |
| <input type="checkbox"/> Consultation Reports   | <input type="checkbox"/> Pathology Reports       |
| <input type="checkbox"/> Other (specify): _____ |  |

Purpose of disclosure:  
 Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: \_\_\_\_\_ Date: \_\_ / \_\_ / \_\_

Print Name:  
\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

