Authorization for Release of Medical Information

Patient Name: _____DOB: __ /___/___

I, _____ hereby authorize the release of medical information

TO/From: 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
secure email: info@gracepointpediatrics.com

FROM/TO:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____Fax : _____

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

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports
___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:_____