

**Preferred Pediatrics of Snowden**

331 Park Hill Drive  
Fredericksburg, VA 22401  
Phone: 540.368.8091 Fax: 540.368.8095

**MEDICAL RECORDS RELEASE AUTHORIZATION**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

If transferring, Why?: \_\_\_\_\_  
\_\_\_\_\_

Please have my physician send the following information: (mark all that apply)

- |                 |                          |             |                          |                             |                          |
|-----------------|--------------------------|-------------|--------------------------|-----------------------------|--------------------------|
| Complete Record | <input type="checkbox"/> | X-Rays      | <input type="checkbox"/> | Consults/Specialist Records | <input type="checkbox"/> |
| Progress Notes  | <input type="checkbox"/> | Health & PE | <input type="checkbox"/> | Prior Physicians Records    | <input type="checkbox"/> |
| Labs            | <input type="checkbox"/> | Shot Record | <input type="checkbox"/> |                             |                          |

**\*\*\* Complete records are those of Preferred Pediatrics physicians only. If you wish to include records from referring and/or previous physicians please be sure to check the consults/specialist records and/or prior physicians records boxes. Preferred Pediatrics only guarantees the accuracy and completeness of records generated by a Preferred Pediatrics physician.\*\*\***

I, \_\_\_\_\_, certify the above request is accurate and hereby authorize the release of these records.

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

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

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**\*\*\* I agree to pay all fees associated with this release, based on the standard fees outlined below. I understand that all section of this form must be completed before it can be processed. \*\*\***

_____ SIGNATURE OF PARENT/GUARDIAN	_____ DATE	_____ PHONE
---------------------------------------	---------------	----------------

**\*\* Virginia law allows for copy charges consisting of the following: \$10.00 administration fee PLUS \$0.50 per page for the first 50 pages and \$0.25 per page thereafter. \*\***

**\*\*Once you transfer or are dismissed from our practice your chart will be sent to our offsite storage facility. If future copies of records are needed there will be a \$25.00 fee to retrieve your chart form our storage facility. \*\***

Storage Retrieval Fee:	\$25.00	Date Copied: _____
Administration Fee:	\$10.00	Date Released: _____
\$0.50 per page up to 50 pages:		Employee: _____
\$0.25 per page thereafter:		
Total Fees:		