



ALEXANDRIA • LORTON • LAKERIDGE

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Each patient must have a separate release form.  
FAX Completed and Signed form to (703) 499-9670*

**Please Print Clearly**

Today's Date: \_\_\_\_\_

**Patient Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

**Date of Birth:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Patient Address:**

I hereby RELEASE and AUTHORIZE ALL Pediatrics to release the medical records of the dependent listed (or self if over the age of 18) including diagnosis, treatment, prognosis and recommendation, as well as other data pertinent to the patient's treatment to the following location listed below. I hereby state that I am the child's parent or legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts.

**Print Name:**

**Signature:** \_\_\_\_\_

**FOR RELEASE OF HIV / DRUG / ALCOHOL AND/OR PSYCHIATRIC INFORMATION,  
AN ADDITIONAL SIGNATURE IS REQUIRED BELOW.**

**Print Name:**

**Signature:** \_\_\_\_\_

**REQUEST BEING MADE FOR THE FOLLOWING:**

- Immunization Record ONLY (No Charge)  Complete Medical Record \* (Fee)

\*Medical Record fee, \$15 up to 20 pages, \$1.00 for each additional 5 pages  
Plus the cost of postage, which is a \$2.00 minimum fee.

**MAIL** Records To:  
(Postage Fee Will be Assessed)

**Pick Up** Medical Records

*Please complete  
all information below.*

**Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_