HAYMARKET PEDIATRICS P.L.C.

AUTHRIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

I understand that I may refuse to sign this form and that my refusal to sign will not affect my child(ren)'s ability to obtain treatment from Haymarket Pediatrics PLC. I understand that certain types of sensitive information in the records I have authorized to be disclosed may not be disclosed under federal or state laws without my authorization and that I may revoke my authorization at any time by contacting the privacy officer at Haymarket Pediatrics PLC in writing except to the extent that Haymarket Pediatrics PLC has taken action in reliance on this authorization. I also understand that if the person or entity that receives the information is not required to comply with the federal privacy regulations, the information described below may be redisclosed and would no longer be protected by these regulations. To facilitate my child(ren)'s treatment by Haymarket Pediatrics PLC and other health care providers who may be involved in the care of those listed below, I hereby authorize the use and/or disclosure of my child(ren)'s medical information as follows:

Edward D. Michel MD

4424 Costello Way, Haymarket, VA 20169
Phone:703 753 1895 Fax: 703 753 4630

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Child's Name ______________________ Date of Birth: ______________________

Child's Name ______________________ Date of Birth: ______________________

I request and authorize ____ to
release health care information of the patient(s) named above to:

Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip Code: ____________

Please send records as requested below to the above address.

☐ Health care information relating to the following treatment, condition or dates: ____________

____

☐ All health care information

☐ Other: ____

PLEASE INCLUDE GROWTH CHARTS and IMMUNIZATION RECORDS

Reason for Release: [] School [] Relocating [] New Provider [] Other

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, sexually transmitted diseases, HIV testing and treatment or mental health treatment to the person(s) listed above.

Signature: ______________________ Date Signed: ______________________

Relationship: ______________________

This authorization expires 1 year after it is signed unless revoked in writing before that.