New Beginnings PEDIATRICS
3708 South Main Street, Suite B
Blacksburg VA, 24060
Phone: 540-739-3623 • Fax: 540-739-3979

Medical Records Release

Patient Name:_____ Date of Birth:_____

I, _____, authorize New Beginnings Pediatrics to release my records to the following person, physician or organization: _____

Person, physician or organization PHONE NUMBER: _____

Person, physician or organization FAX NUMBER: _____

Portion(s) of records to be released include (please check desired items to be released):

- ○ Office Notes:
- ○ Labs/Studies:
- ○ Radiology Reports:
- ○ Other:
- ○ Sensitive Information (examples include: STD Testing, HIV testing, etc)

This purpose of this disclosure is:

- ○ Personal Records
- ○ Continuity of Care
- ○ Transfer of Care
- ○ Insurance Processing
- ○ Legal
- ○ Other: (please explain)_____

I understand that my records are confidential and may be disclosed only as authorized in this consent or as required by law. I also understand that this is revocable by me at any time except that action has been taken in reliance on this consent.

Signature: _____ Date: _____

Relationship to patient: _____

Unless otherwise specified below, this consent will automatically expire after one year from the date above.

Signature: _____ Request consent to expire: _____