Children First Pediatrics of Virginia, P.C.
314 Fairy Street, Suite A
Martinsville, VA 24112
276- 638-5437 (Kids) 276- 666-6686 (Fax)

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____

_____

_____

To release copies of all medical records completed during office visits and/or hospital admissions.

Patient:

Date of Birth:

Address:

Phone #:

Purpose or need for information:

- ☐ **For continuity of care**
- ☐ **Legal Purposes**
- ☐ **Military**
- ☐ **Other** _____

This consent will remain in effect:

- ☐ **1 year from date of signature.**
- ☐ **Until fulfilled.**
- ☐ **90 days from today.**

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

Date: _____ **Signature:** _____

Witness: _____ **Relationship:** _____