Patient's Name: ___________________________________ Date of Birth:________________
Home Address: _________________________City:____________________ State:___ Zip______
Home Phone: ___________________________
Parent or Guardian Name: _________________________

I request and authorize:____
Name of Doctor or Practice

____
Address City State Zip Code

Phone:_______________________ Fax: _____________________

To release my child's records to: **Associates in Pediatrics**
Tamara A. Sutherland, M.D., F.A.A.P.
TamaraA. Charity-Brown, M.D., F.A.A.P.
Joanne Lane, D.O., F.A.A.P.
Charlotte Vellenowith, M.D., F.A.A.P.
11551 Nuckols Road, Suite F Glen Allen, VA 23059
Ph: (804) 364-4400 Fax: (804) 364-0120

Information to be released:
_____ Entire chart
_____ Lab Reports/Diagnostic Reports
_____ Correspondence
_____ Immunization record/Growth chart

Special instructions:________________________
____
____
____
____

This protected information is being disclosed for the following reasons:______________________
____
____
____
____

This authorization expires on:_______________ **or when the following event occurs**:
____

I understand that I have the right to revoke this authorization, in writing, at anytime. The person who receives the records to which this authorization pertains may not re-disclose them to anyone else with out written authorization, except that such person may make a disclosure if it is permitted by law.

____
Printed Name of Parent/Legal Guardian

____ ____________________
Signature of Parent/Legal Guardian Date

____
Relationship to Patient

- Please make sure all sections are complete. If all of the sections are not completed it may delay release of your records.