

Chippenham

Chippenham Pediatric and Adolescent Medicine

Pediatrics

Chippenham Pediatric and Adolescent Medicine, P.C.

Harbour Pointe Office
Suite 100
6510 Harbour View Court
Midlothian, VA 23112-6559
TEL 804.739.8166
FAX 804.639.6614

Old Jahnke Road Office
7023 Old Jahnke Road
Richmond, VA 23225-4126
TEL 804.320.1353 (Primary)
FAX 804.320.6636

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ do hereby authorize the release of my child's/
children's records from:

Chippenham Pediatric and Adolescent Medicine, P.C.

Phone: 804-739-8166 Fax: 804-639-6614

The records are to be forwarded to the following:

Child's Name: _____ DOB: _____

Other Children:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

**PLEASE CIRCLE REASON FOR TRANSFER: AGE INSURANCE CHANGE
RELOCATION FOR A BETTER LOCATION OTHER (PLEASE EXPLAIN):**

PLEASE CIRCLE THE TYPE OF RECORDS REQUESTED: Immunizations Only
Office Notes Only All Records Summary of Records
Basic Records (Immunization Record, Vital History & Last Well Visit)

I understand that I have the right to access my medical records in accordance with the law and the policies of Chippenham Pediatric and Adolescent Medicine, P.C. I understand that Chippenham Pediatric and Adolescent Medicine, P.C. will charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that Chippenham Pediatric and Adolescent Medicine, P.C. has the right to deny me access to my records in certain circumstances in accordance with the law. If Chippenham Pediatric and Adolescent Medicine, P.C. deny me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional. I understand that if I choose to pick up my medical records I will be required to show proper identification before the records will be released.

Please note that information disclosed pursuant to this report is no longer under the control of Chippenham Pediatric and Adolescent Medicine, P.C. and may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature: _____ **Date:** _____

Relationship to Patient: _____

CHIPPENHAM PEDIATRIC AND ADOLESCENT MEDICINE, P.C.

MEDICAL RECORDS FEE SCHEDULE

You have requested either that Chippenham Pediatric and Adolescent Medicine, P.C. release your medical information or a summary of your information to a person or entity outside of Chippenham Pediatric and Adolescent Medicine, P.C. or that you would like to have a copy of your medical records. In accordance with the law, Chippenham Pediatric and Adolescent Medicine, P.C. may charge you a reasonable fee for this service.

- For copies from paper or other hard copy generated from computerized or other electronic storage, Chippenham Pediatric and Adolescent Medicine, P.C. charges:

50 cents per page for first 50 pages

25 cents per page for additional pages

- **Plus all postage and shipping costs.**
- If you request a summary of your medical records Chippenham Pediatric and Adolescent Medicine, P.C. shall charge at a rate of **\$50.00** per hour for a summary preparation.

If you have any questions regarding our fee schedule, please contact our Privacy Office at (804)320-1353.

SIGNATURE: _____ DATE: _____