AUTHORIZATION TO RELEASE MEDICAL RECORDS

To:_____

Address: _____

I authorize the release of the medical records of my son or daughter named below to:

New Horizon Pediatrics
1760 Reston Pkwy., Suite 400
Reston, VA 20190
Phone:703-467-9444 Fax:703-467-8484
NewHorizonPeds@verizon.net

As a person signing this consent, I understand that I am giving my permission to the above-named provider for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in the possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not disclose them to anyone else without my separate written consent unless the such recipient is a provider who makes a disclosure permitted by law.

Patient Name: _____

Other Names Used: _____

Date of Birth: _____

Parent/Guardian Name: _____Date:_____

Signature:_____ Relation: _____