Western Loudoun Pediatrics
201 N. Maple Avenue, Suite 201
Purcellville, VA 20132
Fax: 540-751-8402
Telephone: 540-751-8389

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____

☐ I authorize the release of medical records **to** Western Loudoun Pediatrics **from**:

_____

☐ I authorize the release of medical records **from** Western Loudoun Pediatrics **to**:

_____

****INCOMING RECORDS (TRANSFER TO OUR OFFICE)**

[ ] Immunization record ASAP-Patient in office -*Thank You*

[ ] Remaining Records to follow per your office policy

****OUTGOING RECORDS (TRANSFER TO ANOTHER OFFICE)**

Obtain from the patient portal. Immunization records, growth charts, medication lists, labs and visit notes are available for you to print directly from the patient portal at no cost. The information on the portal will be available for 90 days before your account will be inactivated.

If you need immediate immunization records or require a complete copy of medical records, select from the following options:

[ ] Immunization record only

[ ] All records- $15 Copying fee. Once paid, please allow 5 business days. Records cannot be mailed to a residence.

Circle one: Mail to above practice I will pick up at Western Loudoun Pediatrics (ID required)

Reason for transfer: _____

This authorization will remain valid for 30 days. I may revoke this authorization at any time providing written notice of revocation. However, I may not revoke authorization retroactively for information already released.

I hereby waive all provision of law and privilege to the disclosures hereby authorized.

Printed Name: _____

Signature: _____Date:_____