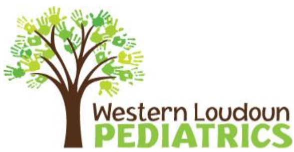

Western Loudoun Pediatrics
17336 Pickwick Drive, Suite 100
Telephone: 540-751-8389
Fax: 540-751-8402

MEDICAL RECORDS RELEASE

Patient Name: _________________________________DOB:____

Patient Name: _________________________________DOB:____

Patient Name: _________________________________DOB:____

Patient Name: _________________________________DOB:____

☐ 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* PLEASE FAX TO 540-751-8402**

[ ] Limited records (immunization record, most recent physical, problem list, medication list & growth charts)

[ ] Other____

PLEASE DO NOT FAX MORE THAN 40 PAGES. THANK YOU.

OUTGOING RECORDS (TRANSFER TO ANOTHER OFFICE)

[ ] Immunization record only

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

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

Reason for transfer: ____

This authorization will remain valid for 180 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.

Parent/Guardian Printed Name: ____

Signature: ____Date: ______________________________________

Contact # ____

Address: ____