Acorn Pediatrics
2610-B Gaskins Road
Richmond, VA 23238
O: 804-548-4700
F: 804-548-4788
help@acornpeds.com

HIPAA Compliant Authorization for Release of Medical Records

Patient Full Name: _____ DOB: _____

I, _____ hereby authorize the release of patient
(Parent or Legal Guardian if patient is under 18)
medical information **TO:**

Doctor/Clinic/Hospital: **Acorn Pediatrics**

Address: **2610-B Gaskins Road, Richmond, VA 23238**

Telephone: **804-548-4700** Fax: **804-548-4788** Email: **help@acornpeds.com**

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax: _____

PLEASE RELEASE THE FOLLOWING:

___ All health records

___ Growth chart, newborn screen, vaccination record, most recent well-child check only

___ Discharge Summary ___ Diagnostic Test Reports ___ Lab Results ___ Consultation Reports

___ Radiology/Images ___ Other (specify): _____

PLEASE EXCLUDE THE FOLLOWING:

HIV information ___

Alcohol/Drug abuse information ___

Sexual assault/victimization information ___

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

If patient is over 18, Signature of Patient: _____ Date: _____

If patient is under 18, Signature of Parent or Legal Guardian: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

By law, you must fill out one form per child.

Please send this to your previous practice or email it to help@acornpeds.com and we will send it for you!