Authorization to Release Healthcare Information

Peds First Healthcare, LLC
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Phone (804) 504-5490 / Fax 833-989-0990

Patient name_____ Date of birth_____

Parent/legal guardian first and last name_____

☐ Medical Records to be released **TO:** Peds First Healthcare

Other facility: Name_____

Address_____

Phone number_____Fax_____

☐ Medical Records to be release **From**:

Peds First Healthcare

Other facility: Name_____

Address_____

Phone number_____Fax_____

By signing this authorization, I am authorizing release of all medical information related to my child's healthcare to include treatment and immunizations. I attest that I am a legal parent or guardian authorized to provide consent. I have a right to revoke this consent in writing excluding information sent prior to the revocation. This consent will remain in effect for 120 days unless revoked.

Records being sent to Peds First Healthcare may be mailed or faxed to address/fax noted above.

Records released to another facility/provider are no charge to you. Please inquire about the fee due for records copied directly to a patient/family.

Parent or legal guardian printed name

Printed first and last name _____

Signature_____

Relationship to patient_____ Phone number _____