2500 N Van Dorn Street, Suite 102
Alexandria, VA 22302
Phone: (703) 933-0555 Fax: (703) 933-0999
Web Address: www.vdpeds.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Van Dorn Pediatrics, P.C to release medical records for following child/ren:

Child Name: **Date of Birth**:

Child Name: **Date of Birth:**

Child Name: **Date of Birth:**

Child Name: **Date of Birth:**

Reason for transfer: (please check one)
- Change of insurance
- Relocation
- Other: ______________________________

Please check one of the following:
- Immunization Record & last physical **ONLY** (No charge)
- Complete Medical Record (Fee)

Please allow 2-5 business days for medical records to be completed.
Medical Record-$25.00 standard fee
Mailing fee-$5.00 extra not included in medical record fee

- **Mail Records or fax to:**
  Name: ____________________________________
  Address: ___________________________
  City: _____________________ Zip Code: ___________
  Phone: ___________________________ Fax: ______________________________
- **Picking Up** (we will notify you by phone when record is ready)
- **Email:** ____

I hereby state that I am the child's parent/legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child/ren.

Relationship to Patient: _______________________________________

Parent/Legal Guardian Signature: ________________________________ Date: _________________