UNION MILL PEDIATRICS
13880 BRADDOCK RD. STE.201
CENTREVILLE, VA 20121
703-802-6304/ 703-802-6307 FAX

MEDICAL RECORD RELEASE AUTHORIZATION

DR. MAURA ERIKSSON
DR. WAYNE ERIKSSON
DR. SHOSHANA KILLIAN
DR. EDEN WOREDEKAL

There is a fee of 0.35¢ per page for the first 50 pages, and 0.25¢ per page thereafter, for the cost of supplies for and labor of copying, as well as storage for the requested information. Postage will be charged on an individual basis. An additional fee of $15 will be added for rush requests inside the allowed 15 day processing. Records requested for an individual age 14 years and up will only be transferred directly to another physician or specialist, unless requested by the individual and he/she is over 18 years of age. Outstanding bills are due immediately with a forwarding address. Non-reconciled accounts are subject to collections 30-days following records transfer. Use of services and facilities after 30-day grace period are considered unauthorized and patients will be billed per usage. Records requests are handled pursuant to federal and state regulations, including Virginia code 32.1-127.1:03

☐ Immunization Records **only** (*No charge*)

Date: _____ I authorize the release of ☐ my own ☐ my child(ren)'s medical records from (date) _____ to (date) _____. ☐ All Records

Please forward all records to the following address: (Please print clearly)

To (Practice/Doctor's Name): _____

Address: _____

_____

_____

Review Appointment: *(If records will be hand transported)* ☐ MADE ☐ DECLINED

Reason for records transfer: _____

Current billing address: _____

_____

Telephone: _____ Alternate Telephone: _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

I understand that I am responsible for providing correct and legible information. Should I choose not to have these records sent directly to another doctor's office, I understand that per Union Mill Pediatrics' Policy, I must make or decline an appointment to review them in the office prior to taking them, and further agree accept complete responsibility for the safe keeping of the records I take.

Signature: _____ Date: _____
Individual 18+, Parent or Legal Guardian

PAYMENT: $_____ CASH: _____ CREDIT CARD: _____ CHECK#: _____

DATE PAYMENT RECEIVED: _____ PAYMENT TAKEN BY: _____

RECORDS PROCESSED BY: _____ MAIL/PICK UP: _____