Chester Pediatrics, P.C.
Pediatric and Adolescent Medicine
4707 Buckingham Ct. Chester, VA 23831
Phone: 804-748-9090, Fax: 804-751-4815

Authorization to Release Healthcare Information

NOTE: We have contracted with HealthPort to process your request for medical records and they will invoice you directly; as soon as the invoice is paid your records will be mailed.

The fee for providing a copy of your medical records is $.50 (per page up to 50 pgs) then an additional $.25 per page (from page 51 & up) + cost of actual postage

Patient record to be released:

Patient Name:	**Date of Birth:**

By signing this authorization, I authorize the following organization to release information as stated below from the patient health record:

Information Release TO: ☐ Chester Pediatrics **or**

_____

Name **Street Address** **City** **State** **Zip** **Fax**

Information Release FROM: ☐ Chester Pediatrics **or**

_____

Name **Street Address** **City** **State** **Zip** **Fax**

Billing Address:

_____

Name **Street Address** **City** **State** **Zip**

Information to be released:

☐ Immunization record only ☐ All healthcare information ☐ Other-please specify: __

This information is being requested for the purpose of:

☐ Referral to specialist ☐ Insurance ☐ Legal ☐ Transfer ☐ Personal ☐ School ☐ Other

I understand that this authorization will expire in 90 days from the date signed below unless another date event is entered here: _____

_____ _____ _____

Signature of patient or legal guardian Phone Number Date

_____

Relationship to patient