Yum Pediatrics
10482 Georgetown Drive, Suite A
Spotsylvania, VA 22553
Phone: (540) 369-3316
Fax: (540) 369-3317

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Patient: _____ DOB: _____
Patient: _____ DOB: _____
Patient: _____ DOB: _____
Patient: _____ DOB: _____
Patient: _____ DOB: _____
Patient: _____ DOB: _____

Address: _____
Phone: _____

I, _____, certify the above request is accurate and hereby authorize the release of these records.

TO:

☐ **Doctor's office name** _____
Address: _____
Phone: _____
Fax: _____

☐ **I will pick up a CD (we will notify you when ready)**

*** Records requested after November 31st may incur a records fee of $25***

_____ _____ _____
SIGNATURE OF PARENT/GUARDIAN DATE PHONE

Please email this form to office@yumpediatrics.com or upload it to a portal message.

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Yum Pediatrics from, and covenant not to sue Yum Pediatrics for any claim that I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy information used/disclosed under this authorization. I understand that I may revoke this consent to release information at anytime, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire six months after the date specified below, or on the date, event or condition described as: