REV 11/1/2018

AUTHORIZATION FOR NOVA TO RECEIVE PROTECTED HEALTH INFORMATION (PHI)

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB _____

Please check the item that pertains to your request:

- ❒ Immunization Records
- ❒ Last Physical Exam
- ❒ State / County Physical Form
- ❒ Medical Records
- ❒ Other (Please Specify) _____

Reason for Request of PHI (release of records)_____

PHI Released To:

NOVA Pediatrics
1483 Old Bridge Rd. #201
Woodbridge, VA 22192
Phone (703)491-2141 Fax (703)690-0815

PHI Receiving From:

_____
_____
Phone #:_____
Fax #:_____

_____
Signature of Patient or Legal Guardian

_____
Relationship to Patient

_____
Print Name of Patient or Legal Guardian

_____
Date

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Nova Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Nova Pediatrics' Privacy Officer at 6120 Brandon Avenue, Springfield, VA 22150.

OFFICE USE ONLY:

Date Request Sent: _____ Initials: _____

Date Received: _____ Initials: _____