HIPAA
MEDICAL RELEASE FORM

20745 Williamsport PL, #340
Ashburn VA 20147
P: 703-445-3472
F: 877-769-2755

Patient's Full Name: ___________________________________ Date of Birth: ________________

Street Address:____

City, State, Zip: _______________________________________

I, _____________________________________ Do hereby Authorize **One Pediatrics PLLC** to
(Parent/Guardian)
release:

◯ Complete Medical Records ◯ Immunization Record & Last Physical Exam

Release information to : ____
Name of Company/Facility/Person

____
Street Address

____
City, State, Zip

____ _______________________________________
Phone Number Fax Number

Signature of Parent/Guardian: ____

Date of Request: ____________________ Relation to Patient:_____________________________