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

HIPAA Request of information
AUTHORIZATION FORM

I, _____ hereby authorize _____
(PARENTS NAME HERE) **(*LAST* PEDIATRICIAN OFFICE HERE)**
and its affiliates, its employees and agents, to release to **Dr Hind BOUALLALI , One Pediatrics PLLC** my child's health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to my child and which identifies my and my child's name, address, social security number, Member ID number). I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my signature below and shall expire the date I revoke it in writing. However, this authorization may not be revoked if action have already been taken on this authorization prior to receiving my written notice. I also understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my/ child's eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____ **D.O.B**:_____

Requested records: Well check visits Immunizations Labs Other: _____

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Print name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____

Date: _____