1123 Heatherstone Dr. • Fredericksburg, VA 22407 • Phone: 540-899-2555 • Fax: 540-899-3554
Claudia Sussdorf, M.D. • Jacinta White Topps, M.D. • Sita Canady, M.D. • Auri Caudill, M.D •

MEDICAL RECORDS REQUEST

There will be a fee for the requested records. Please allow a minimum of 1-3 weeks for processing
When requesting an entire medical record hand-carried copy or transfer, all medical records will be released; to include any correspondence from outside doctor's offices. You may revoke this request to our office, in writing, at any time. This signed release will expire one year from the date written at the bottom of this page.

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

- Name: _____ DOB: ____/_____/_____
- Name: _____ DOB: ____/_____/_____
- Name: _____ DOB: ____/_____/_____
- Name: _____ DOB: ____/_____/_____

Please circle TO/FROM appropriately to avoid delays in record processing

TO / FROM:

☐ Fall Hill Pediatrics
1123 Heatherstone Drive
Fredericksburg, VA 22401

Phone: 540.899.2555
Fax: 540.899.3554

TO / FROM:

Name:_____
Address: _____
_____

Phone: _____
Fax: _____

☐ **All Medical Records** ☐ **Immunization Records Only** ☐ **Specific dates of service from:___/____/_____to ____/____/_____**

If Fall Hill Pediatrics is releasing your child(ren)s' medical records to you or to another party such fees are associated. Please allow a minimum or 1-3 weeks for processing.

☐ Charge for individual record - $20.00 ☐ Charge for retrieval from storage facility - $30.00

I acknowledge that patient medical records may include personal information, such as: drug or alcohol abuse, psychiatric evaluations, HIV testing, etc. I understand that my signature on this medical request form is my affirmation that I have read, agree to, and understand all of the terms stated herein, and that I acknowledge that by signing below, I am providing Fall Hill Pediatrics my full consent to have the above requested medical records copied and transferred to the appropriate medical facilities and/or physicians listed herein.

_____ _____ _____

Signature of Parent, Patient or Guardian **Date** **Phone Number**

_____ _____

Printed Name of Parent, Patient or Guardian **Relationship**