Kenneth J. Kim Pediatrics
3930 Pender Drive Suite 330
Fairfax, VA 22030
Tel: 703-246-0022 Fax: 703-246-0080

Authorization to Release Health Information

I request and authorize the release of medical records of below individuals for purpose of continued care:

Name: _____ **Date of Birth: ____/____/_____**

Name: _____ **Date of Birth: ____/____/_____**

Name: _____ **Date of Birth: ____/____/_____**

Type of Medical Records:

[ ] Immunization Records
[ ] Last Physical Exam
[ ] All Medical Records
[ ] Other (Please specify) _____

Records Released From:

Kenneth J Kim Pediatrics
3930 Pender Drive Suite 330
Fairfax, VA 22030
Tel: 703-246-0022
Fax: 703-246-0080

Records Released to:

Name: _____

Address: _____

_____

Phone: _____ **Fax:** _____

I understand that I have the right to revoke this authorization by notifying Kenneth J Kim Pediatrics in writing except to the extent that action was already taken in reliance on this signed authorization. I understand that when information used or disclosed from this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

I understand that I am responsible for financial fee associated with the request. I understand that the charge is 50 cents per page for the first 50 pages, 25 cents for each additional, and $10 processing fee.

_____ _____
Signature of Parent or Legal Guardian/ Patient (if 18 or older) Relationship to Patient

_____ _____
Print Name of Person Signing Date

Office Use:
Amount Charged: _____ Doctor Signature: _____
Date Processed: _____