



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

6120 Brandon Ave. #308

Springfield, VA 22150

Phone (703)451-3333 Fax (703)451-7219

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: _____