AKSHAR PEDIATRICS

7474 Limestone Dr, Gainesville VA 20155 | (P) 703-721-7218 | (F) 703-721-7219

CONSENT TO RELEASE MEDICAL RECORDS

Physician Office Releasing Records:

Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax: ____________________
Email ID: ____________________

Records to be released to:

Akshar Pediatrics LLC
7474 Limestone Dr
Gainesville, VA 20155
Phone: 703-721-7218
Fax: 703-721-7219
Email ID: medicalrecords@aksharpediatrics.com

Patient Names

____________________ DOB: ____________________
____________________ DOB: ____________________
____________________ DOB: ____________________
____________________ DOB: ____________________

Medical Information to be sent:

- ☐ Complete Charts (includes but not limited to HIV, Mental Health and Substance Abuse Information)
- ☐ Office Visit Notes
- ☐ Vaccine Records
- ☐ Laboratory and/or X-Ray Results
- ☐ Other records for the dates from _______________ to ________________

I authorize medical information to be released as indicated above. I understand release is effective for 60 days from the date of execution. However, I may revoke my consent at any time by providing written revocation to the above-named physician.

______________________________ ______________________ ____________
Parent/Guardian Name **Phone** **Date**