The Pediatric Group, PC

Pediatric & Adolescent Medicine

Lake Ridge Office
13001 Summit School Rd
Lake Ridge, VA 22192
703-494-4811 (Office)
703-494-2098 (Fax)

Samantha G. Cutler, M.D.
Pooja Prasad, D.O.
Jodi Natovitz, M.D.
Farha Naqui, M.D.
Emily Zgorski, CPNP

Patriot Square Office
10527 Braddock Road
Fairfax, VA 22032
703-425-3300 (Office)
703-323-3950 (Fax)

Elizabeth Palumbo, M.D.
Aarti Kapoor, M.D.
Mary Grigis-Nolan, CPNP
Kim McCuen, CPNP

Manchester Lakes Office
7015C Manchester Blvd
Alexandria, VA 22310
703-971-6900 (Office)
703-971-7673 (Fax)

Evie K. Cavros, M.D
Eugenia Lin, M.D.
Michele Davitt, M.D.
Jennifer Schmidt, CFNP

Chantilly Office
3914 Centreville Road, #101
Chantilly, VA 20151
703-481-8600 (Office)
703-481-8618 (Fax)

Candace Fugate, M.D.
Y. Nina Niu, M.D.
Irene Tham, M.D.
Dena Taylor, CPNP
Jamie Fairgrieve, PA-C

Consent to Release Form

Any patient over age 18 years must sign his/her own release. *

Please Print: Each form MUST be completely filled out and contain a signature in order to process! Please print all information **except** signature.

Date of Request: _____

Patient Name: _____ Date of Birth: _____

I understand that by signing this form, I am allowing the medical information concerning the above patient released from

Name and Address of Physician Releasing the Medical Information:

_____

_____

_____

To: **The Pediatric Group, PC**
13001A Summit School Rd.
Woodbridge, VA 22192

The Pediatric Group, PC
10527 Braddock Road
Fairfax, VA 22032

The Pediatric Group, PC
7015C Manchester Blvd
Alexandria, VA 22310

The Pediatric Group, PC
3914 Centreville Road, #101
Chantilly, VA 20151

As per my request, the reason for releasing the information is: ____ Continued Medical Care ____ Legal ____ Insurance ___ Other

I understand that the information to be released may include information in the following categories unless I specifically deny the release (Initial any category to not be released.)

Substance abuse _____ Mental Health _____ HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

_____ _____
Signature of Parent or Guardian/ Patient (if 18 or older) **Date**

_____ _____
Relationship to Patient **Witness**

Patient's Complete Mailing Address:

_____

_____

_____

_____

Phone Number (Day Time):

_____