AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Patient DOB: _____ / _____ / _____

ID Number: _____

By my signature below, I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary. 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.

Records to be provided by: [INSERT YOUR PRACTICE NAME HERE]

Describe the records to be sent:

- ❑ Complete record
- ❑ Records of care from the following dates: _____ to _____
- ❑ Records concerning the following conditions: _____
- ❑ Other, please specify: _____
- ❑ Permission to speak with person(s) listed below about my medical information:

  _____

Describe the reason or purpose for this release:

- ❑ Consultation or treatment by another provider
- ❑ Other, please specify: _____

When would you like this authorization to expire? Expiration date: _____ / _____ / _____

If no date is given, this authorization will automatically expire in 6 months.

I understand that:

[INSERT YOUR PRACTICE NAME HERE] will provide this information within 30 days from the date of this request.

I may revoke this authorization at any time by notifying [INSERT YOUR PRACTICE NAME HERE] in writing. Revoking this authorization will not affect releases and disclosures already provided in response to this authorization.

If I refuse to sign this form my treatment at [INSERT YOUR PRACTICE NAME HERE] will not be affected in any way.

I am responsible for payment of a fee for preparing and furnishing this information. Charges will comply with the Virginia Statutory Code.

If I have questions about the release of my medical records, I can contact the medical records department.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Print Name Relationship to Patient

_____

Witness Signature