# *Internal Medicine Group of Northern VA*

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PRINT Patient Full Name _____ Birth Date (Month/Day/Year) _____

Street Address _____ Social Security Number _____

City, State, Zip Code _____ Phone (Home) _____

At the request of the individual, I _____, (Patient Name or Parent Name) do hereby authorize_____ (Name of Facility) to release:

RECORDS ARE REQUESTED FOR THE FOLLOWING DATES/TIME PERIODS:_____

| | | |
|---|---|---|
| ___ LAST 2 YEARS ONLY | ___ PATHOLOGY REPORTS | ___ EMERGENCY REPORTS |
| ___ HISTORY & PHYSICAL | ___ LABORATORY REPORTS | ___ ALL RECORDS |
| ___ PROGRESS NOTES | ___ RADIOLOGY REPORTS | ___ DISCHARGE SUMMARY |
| ___ OPERATIVE NOTES | ___ ECG/EEG/CARDIC CATH | ___ OTHER _____ |

___ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Acquired Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

**INFORMATION RELEASE TO:** _____

Name of Company/Agency/Facility/Person

_____

Street Address

_____

City, State, Zip

**PURPOSE OF DISCLOSURE:**

| | | | |
|---|---|---|---|
| ___REFERRAL TO SPECIALIST | ___INSURANCE | ___WORKERS COMP. | ___LEAVING PRACTICE |
| ___LEGAL INVESTIGATION | ___DISABILITY DETERMINATION | ___PERSONAL | ___RELOCATION |

**Please provide current DAYTIME telephone number:** (_____)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of the individual, guardian or Personal Representative of patient estate. **(Power of Attorney must be on file with the office or accompanying this request)** Date

NOTE: There will be a charge for copies of your medical records requested from this office. Virginia State Rates from code § 8.01-413 apply as pages 1-50 at $0.50 per page, pages 51+ at $0.25 per page, all postage and shipping cost and up to $20 search and handling fee will be applied. RECORDS WILL BE PROCESSED AND MAILED ONCE PAYMENT HAS BEEN RECEIVED.

MEDICAL INFORMATION RELEASED BY:_____ DATE:_____