

Authorization for Release of Information

Please send completed form to : Patient First Medical Records, PO Box 5411, Glen Allen, VA 23058 or Fax to (804) 968-4269

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ - _____ - _____ SS#: _____ - _____ - _____
MO DAY YR

I hereby authorize Patient First or _____ (Print Name of Provider) to release my medical record and/or items checked below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I give my permission for _____ to pick up the information to be released.

INFORMATION TO BE RELEASED:

Date(s) of Visit(s):

- | | |
|---|-------|
| <input type="checkbox"/> Medical Record | _____ |
| <input type="checkbox"/> X-rays | _____ |
| <input type="checkbox"/> EKG | _____ |
| <input type="checkbox"/> Itemized Statement | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

- PURPOSE OF DISCLOSURE:**
- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Changing physicians | <input type="checkbox"/> Consultation/second opinion | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Legal | <input type="checkbox"/> School |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> At my request (You are not required to give a reason.) | |
| <input type="checkbox"/> Other (please specify): _____ | | |

- I understand that if Patient First has requested this authorization, then I will get a copy of this form after I have signed it.
- I understand that this authorization will be valid for one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information disclosed to the above individual or organization may be redisclosed and not protected by the Federal Privacy Rule.
- I understand that my right to receive medical services from Patient First will not be affected if I refuse to sign this authorization.
- I understand that if my record contains information related to substance abuse, HIV related information and/or mental health information, that information will be released with my medical record.

Signature of Patient/Legal Guardian/Personal Representative

Date

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so.