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AUTHORIZATION TO RELEASE MEDICAL/DENTAL RECORDS

Patient Name _____Contact Phone Number_____

SS# _____ Patient Date of Birth_____

Patient Address _____

At the request of the individual, I (patients name) _____do hereby authorize (name of office/facility) _____ to release medical/dental information concerning my medical/dental treatment to the party listed below:

INFORMATION RELEASE TO:

Name _____
Street Address _____
City/State/Zip _____
Phone# _____Fax# _____

Information to be Released/Disclosed:

- Complete Medical/Dental Record
- Specific date range from _____to _____
- Other (please specify) _____

Reason for Disclosure:

- Transfer of Care
- Workers' Comp
- Personal
- Insurance
- Other

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization and can be addressed to the company listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that there may be a charge for personal copies of my medical record allowed under Virginia Statute. The first fifty pages are $0.50 per page, every additional page over fifty is $0.25.

I understand that this disclosure may include information regarding drug/alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) of infection with HIV regulated by Federal Statute (42 CFR Part2)

Signature of Patient/Representative or Guardian _____
Date (authorization will expire 12 months from date signed) _____