Virginia Physicians, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name_____

Date of Birth _____ SSN _____

Home _____ work _____ cell_____

Release records to:	Release records from:
_____	_____
(physician or facility)	(physician or facility)
_____	_____
(address)	(address)
_____	_____
(city, state, zip)	(city, state, zip)
_____ _____	_____ _____
(phone) (fax)	(phone) (fax)

Reason for Request: _____

Information to be released:

_____ completed health records

_____ Office notes – dates from _____ to _____

_____ Immunizations Labs only_____ X-Rays only_____

Other: _____

I Do _____ or I Do Not _____ authorize the release of information related to:

- AIDS (Acquired Immunodeficiency Syndrome)
- HIV (Human Immunodeficiency Virus) Infection
- Psychiatric care and/or Psychological assessment
- Treatment for alcohol and/or drug abuse

Copying fees for records provided by Virginia Physicians Inc are as follows:

$10.00	Processing Fee
$00.50	per page for initial 50 pages
$00.25	per page for each additional page
$25.00	X-Ray films minimum $25.00 for each additional set of three films

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 the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Parent/Guardian/Representative _____ Date _____