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)	_____ (phone)
_____ (fax)	_____ (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 _____