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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE FILL OUT ALL SECTIONS

Patient's Name (print clearly)_____

Date of Birth_____ **SSN**_____

Contact Telephone #_____

Information RELEASED FROM:	**Information RELEASED TO:**
_____	_____
_____	_____
_____	_____
Phone Number_____	**Phone Number**_____
Fax Number_____	**Fax Number**_____

Reason for Request:_____

Information to be released:
____Complete health records _____Immunization Record Only
____Office notes – dates from_____to _____
____Lab Reports – dates from_____to_____
____X-Ray Only – dates from_____to_____ Area of Body_____
____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 and treatment for alcohol and/or drug abuse.

Copying fees for records provided by Midlothian Family Practice are $0.50 per page for the initial 50 pages and $0.25 per page for each additional page, plus $10 processing fee. Copying fees for x-ray films is a minimum of $25 and $25 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.

_____**Date**_____
Signature of the patient, parent/guardian if minor or authorized representative

If signed by person other than patient, state relationship to patient:_____
If signed by authorized representative, state why patient is unable to sign:_____

_____

Midlothian FAMILY Practice
Caring for Midlothian Since 1893