Authorization for Release of Protected Health Information

Name of Patient: _____ **Date of Birth:** _____

The office of Virginia Physicians, Inc is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on _____ number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** _____ **Phone Number:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person** _____ **Relationship:** _____ **Phone Number:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____ **Relationship:** _____ **Phone Number:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Virginia Physicians, Inc.