Authorization for Release of Protected Health Information

Name of Patient (Printed): _____ **Date of Birth:** _____

Entity to Receive Information Check each person or class of persons that you approve to receive health information	**Description of Information to be Released** Check each type of health information that can be given to person/entity on the left in the same section
☐ **Spouse or Partner:** **Name:** _____ **Relationship:** _____ **Telephone Number:** _____	☐ **Appointment Reminders** ☐ **Lab Results** ☐ **Treatment Notes and Record** ☐ **Discuss Treatment**
☐ **Additional Person:** **Name:** _____ **Relationship:** _____ **Telephone Number:** _____	☐ **Appointment Reminders** ☐ **Lab Results** ☐ **Treatment Notes and Record** ☐ **Discuss Treatment**
☐ **Additional Person:** **Name:** _____ **Relationship:** _____ **Telephone Number:** _____	☐ **Appointment Reminders** ☐ **Lab Results** ☐ **Treatment Notes and Record** ☐ **Discuss Treatment**
☐ **Additional Person:** **Name:** _____ **Relationship:** _____ **Telephone 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.

Ashland Medical Center