AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
PLEASE FILL OUT ALL SECTIONS

Patient's Name (print clearly)____

Date of Birth______________________ **SSN**______________________________

Contact Telephone # Home_______________________ **Cell**___________________________

Information RELEASED FROM:	**Information RELEASED TO:**
______________________________ (Facility)	______________________________ (Facility)
______________________________ (Address)	______________________________ (Address)
______________________________ (City, State, Zip)	______________________________ (City, State, Zip)
______________________________ (phone)	______________________________ (phone)
______________________________ (fax)	______________________________ (fax)

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:_______________________

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