VIRGINIA CENTER for WOMEN

A division of Mid-Atlantic Women's Care, PLC

Obstetrics, Gynecology & Infertility

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Phone: H) _____ **Phone: C)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Record

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility phone:** _____

Facility Address: _____ **Facility fax:** _____

City, State, Zip: _____

Date and Type of Information to Disclose:

- ☐ 2 years prior from last seen
- ☐ Dates Other: _____
- ☐ Specific Information Requested: _____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral or other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified as stated in **Sec. 164.524.**

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records**

Fax: _____ **Phone:** _____ ☐ **Please fax record**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice's Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, even, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Practice's Privacy Officer.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient/Parent/Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status) — Date

_____ _____

Printed Name of Authorized Representative — Relationship/Capacity to Patient

_____

Address and telephone number of authorized representative