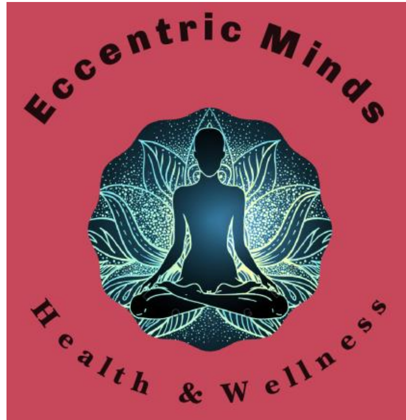
4410 East Claiborne SQ
Suite 334
Hampton, VA 23666
757-333-0175
Fax 401-210-3750



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
Medical Records Release Form

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENERAL DISEASE, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, HERPES, SYPHILIS, GONORRHEA, AND HUMAN IMMUNE DEFICIENTY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

PATIENT'S NAME	BIRTHDATE		SOCIAL SECURITY NUBMER

I AUTHORIZE AND
REQUEST____
(Name of Physician/Practice or Agency Releasing Information)

RELEASE COPIES OF MEDICAL RECORDS TO:	OBTAIN COPIES OF MEDICAL RECORDS FROM:

4410 East Claiborne SQ
Suite 334
Hampton, VA 23666
757-333-0175
Fax 401-210-3750

PURPOSE OF THIS RELEASE: □CONTINUITY OF CARE □MEDICAL PAROLE □OTHER _______________

SOCIAL SECURITY/DISABILITY PERSONAL USE LEGAL PURPOSES

THE EXTENT OR NATURE OF INFORMATION TO BE RELEASED: TIME PERIOD
FROM______________TO______________

□PROGRESS NOTE □RADIOLOGY □MENTAL HEALTH □PHYSICIAN'S ORDERS
□LAB WORK □OPTHALMOLOGY □HISTORY AND PHYSICAL □DENTAL
□ENTIRE MEDICAL RECORD
□OTHER____

DATE UPON WHICH AUTHORIZATION EXPIRES :____________________________________(If left blank will expire in 180 days)

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME UNLESS ACTION HAS ALREADY BEEN TAKEN BASED UPON IT, AND THAT IN ANY EVENT THIS AUTHORIZATION EXPIRES IN NINETY (180) DAYS FROM THE DATE OF SIGNING OR UPON THE CONDITIONS(S) DESCRIBED ABOVE.

____
____

Patient **Date**

____

___________________ ____ ______
Legal Representative/Guardian **Describe authority to act on behalf of the individual** **Date**

CERTAIN STATUTES, STATE AND FEDERAL, MAY PROHIBIT FURTHER DISCLOSURES OR RELEASE OF THE ABOVE INFORMATION WITHOUT SPECIFIC WRITTEN AUTHORIZATION FOR RELEASE OF THE PERSON(S) ABOUT WHOM IT PERTAINS. THIS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION IS NOT INTENDED TO AUTHORIZE FURTHER RELEASE OR DISCLOSURE. REDISCLOSURE OF MY MEDICAL RECORD BY THOSE RECEIVING THE ABOVE INFORMATION MAY BE ACCOMPLISHED WITHOUT MY FURTHER WRITTEN AUTHORIZATION AND MAY NO LONGER BE PROTECTED.