

LOUDOUN MEDICAL GROUP
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient full name

_____/_____/_____
Birth date

Street address

_____-_____-_____
Social Security Number

City/State/Zip

(_____)_____-_____
Home telephone

At the request of the individual, I _____, do hereby authorize

_____ to release:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Emergency Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Other _____
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Reports	_____
<input type="checkbox"/> Operative Notes	<input type="checkbox"/> ECG/EEG/Cardiac Cath	_____

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/facility/Person

Street Address

City/State/Zip

PURPOSE OF DISCLOSURE:

Referral to specialist Insurance Workers Comp Change of Doctor/Provider
 Legal Investigation Disability determination Personal Continuing care
Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home or work or cell) (_____) _____ - _____

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 I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's estate**

Date

NOTE: There may be a charge for a personal copy or the permanent transfer of your records as follows: a \$10 base fee, \$.50 per page for pages 1-50, then \$.25 for any pages over 50.