

Patient's Name: _____

Account# _____

Social Security Number (optional): _____

Patient's Date of Birth: _____

Patient's Telephone Number: (Daytime) _____

(Evening) _____

I authorize: **FAIRFAX OB-GYN ASSOCIATES, 3650 Joseph Siewick Drive, Suite 203, Fairfax, VA 22033**

To release or disclose the following information to:

Name of Person, Physician or Agency to receive information

(Fax number for physician office only)

Street Address

City

State

Zip Code

Information to be Released/Disclosed:

DATE(S) OF SERVICE: _____

Emergency Record

X-ray Report

Billing Information

Face Sheet

Progress Notes

Substance Abuse Records

Discharge Summary

Lab / EKG

Plan of Care (HH)

Psychiatric Admit Note

Operative Report

Complete Health Record

Psychiatric Evaluation

Physicians Orders

Medical Abstract

Consultation

Other _____

X-ray films/CD

History & Physical

Purpose: Please indicate reason for record transfer:

Changing doctor because _____ Moving Insurance Changed to _____

Dissatisfaction with service. If so, please comment: _____

Other, please explain _____

Patient Advised of Charges Yes No N/A

NOTE: Virginia Code 8.01-413B requires that records be provided within 15 days for a charge not to exceed fifty cents per page for the first 50 pages and twenty-five cents for each additional page and a fee not to exceed ten dollars for searching, handling and mailing the records. Virginia Code 32.1-127.1:03 Section J refers to the imposing of fees for copying individual health records. Our cost based fees are the same as listed above.

I prefer to pick up records I wish to review records (by appointment only) Please mail

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand Fairfax OB-GYN Associates, P.C. may not condition treatment on my decision to sign this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

Signature of Patient or Representative

Date (This authorization will expire 6 months after date signed)

Name of Personal Representative (If applicable)

Relationship to Patient

Staff/Copy Service Signature: _____

FEE\$ _____ NO FEE

ID Obtained Signature Checked Other TYPE OF ID: _____

Records Released By: _____

Date Released: _____