NOVA PHYSICIAN WELLNESS CENTER

3903 Fair Ridge Drive, Ste. # 209, Fairfax, VA 22033

19415 Deerfield Ave, Ste.# 202, Lansdowne, VA 20176

8130 Boone Blvd, Ste. # 110, Vienna, VA 22182

4820 31st St. South, Ste. B Arlington, VA 22206

P: 703-865-6490

F: 703-865-6492

PATIENT ID #_____

Authorization for Release of Information

THIS FORM MUST BE FILLED OUT COMPLETELY TO BE VALID.

PATIENT NAME: _____ _____ _____ _____

LAST **FIRST** **MI** **MAIDEN OR OTHER NAME**

DATE OF BIRTH: _____/_____/_____ SS#___ ___ ___ - ___ ___ - ___ __ __

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

I HEREBY AUTHORIZE: _____ (PRINT NAME OF PROVIDER) *TO*

RELEASE INFORMATION FROM MY MEDICAL RECORDS TO:

NAME: **Dr. Rohit Suri**_____

ADDRESS: 3903 Fair Ridge Dr., SUITE 219 CITY: Fairfax STATE: VA ZIP: 22033

PHONE: 703-865-6490 FAX: **703-865-6492**

INFORMATION TO BE RELEASED:

Dates to be released:

☐ Medical Record ☐ Itemized statement _____

☑ OTHER: EKG AND Lab Reports_____ _____

PURPOSE OF DISCLOSURE:

☑ Continuing care ☐ Changing physicians ☐ Consultation/second opinion

☐ Workers compensation ☐ Legal ☐ Insurance ☐ At my request (You are not required to give a reason)

☐ Other (Please specify):_____

♦ I understand that if Nova Physician Wellness Center has requested this authorization, then I will get a copy of this form after I have signed it. ♦ I understand that this authorization will be valid until otherwise instructed by the patient ♦ I understand that I may revoke this authorization at any time by notifying the provider organization in writing, and it will be effective on the date notified expect to the extent action has already been taken in reliance upon it. ♦ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal privacy regulations. ♦ I understand I may see a copy of the information described on this form if I ask for it. ♦ I understand that my right to receive medical services from Nova Physician Wellness Center will not be affected if I refuse to sign this authorization.

X _____ _____ **OR** _____ _____

SIGNATURE OF THE PATIENT **DATE** Parent/Legal Guardian/Authorized person Date