

LOUDOUN MEDICAL GROUP
AUTHORIZATION FORM

Patient Name _____ DOB: _____
Address _____
Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____
Date _____

I, _____, give my permission to Loudoun Medical Group PC to use or disclose my personal health information in the manner described below. I have been told that I am under no obligation to sign this authorization form and that Loudoun Medical Group PC will not condition treatment or its payment on my decision to sign this form. I have signed this form voluntarily.

The following is a description of my personal health information that I authorize to be used and/or disclosed:

The following is a listing of person(s) and/or organizations that I authorize to receive my personal health information as per the limitations listed above. I have been told that if the person(s) and/or organizations listed below are not health care providers, a health plan or a health care clearing house, that they are not subject to the same federal privacy rules and that they may disclose my health care information without obtaining my permission.

The following is a description of the purpose(s) for which my health care information may be used and/or disclosed to the previously mentioned person(s) and/or organizations.

I understand that I may revoke this authorization at anytime by asking to complete a revocation form that Loudoun Medical Group PC will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form but if I do sign it, I must be provided a copy of the signed form.

I understand that prior to signing this authorization form, I have the right to inspect and/ or copy the health information which will be used or disclose pursuant to this authorization.

This authorization will expire on _____

I _____ (print name) have had the opportunity to read and understand the contents of this authorization form and my signature confirms that this authorization form accurately reflects my wishes.

I understand that if I am receiving a copy of my medical record, Loudoun Medical Group reserves the right to charge for this as follows: \$10 base fee, \$0.50 per page for pages 1-50, and \$.25 for any pages over 50.

Signature

Date

IF PATIENT UNABLE TO SIGN AUTHORIZATION FORM

_____ (print name) is unable to sign because

_____.

_____ (print name) is the personal representative and has the following relationship to the patient, _____. The authority of the personal representative is _____.

Personal Representative (print name) _____

Signature: _____

Date: _____