AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____ ID Number: _____

Persons/organizations providing the information:	Persons/organizations receiving the information:
_____	_____
_____	_____
_____	_____
_____	_____

INFORMATION TO BE DISCLOSED

Specific description of information (if available, please include dates of service):

_____ Entire Medical Record
_____ Laboratory Reports
_____ Operative Reports
_____ Other _____
_____ Office Notes
_____ X-Ray Reports

Specific description of the purpose of the use or disclosure:

_____ Continuity of Care (specialist/new PCP)
_____ Disability Determination
_____ Vocational Rehabilitation Evaluation
_____ Other _____
_____ Legal
_____ Personal Records
_____ Payment of Insurance Claims

- I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
- I understand I may revoke this authorization by notifying the providing organization in writing, but if I do, it will have no effect on any actions performed prior to the revocation. If not previously revoked, this authorization will expire in 12 months.
- I understand that I may be given a copy of this signed form if I ask for it. A photocopy or facsimile of this authorization will be treated in the same manner as the original.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN/REPRESENTATIVE **DATE**
(Form *MUST* be completed before signing.)

_____ _____
PRINTED NAME OF PATIENT'S REPRESENTATIVE **RELATIONSHIP TO THE PATIENT**

Note: There may be a charge for the release of medical records. Our fee is based on Virginia Code 8.01-413, which requires that records be provided within 15 days, for a charge not to exceed $20.00 plus all postage and shipping costs.