3903 Fair Ridge Dr Suite 219, Fairfax, VA 22033
703-865-6490 Phone
703-865-6492 Fax

MEDICAL RECORD #:_______ - _______________
Center # Patient #

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# ________________________
MM DD YY

ADDRESS: ______________________________ CITY: _______________ STATE: ________ ZIP: _______

I HEREBY AUTHORIZE______________________________(PRINT NAME OF PROVIDER) TO RELEASE INFORMATION FROM MY MEDICAL RECORD 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

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol / drug abuse)
- ☐ HIV related information (AIDS related testing)

X____
Signature of Patient Or Legal Guardian Date

(SIGNATURE FOR THIS SECTION ONLY.)

PURPOSE OF DISCLOSURE:

- ☒ Continuing Care
- ☐ Workers Compensation
- ☐ Other (Please specify):____________________________________
- ☐ Changing physicians
- ☐ Legal
- ☐ School
- ☐ Consultation/second opinion
- ☐ Insurance
- ☐ At my request (You are not required to give a reason.)

- 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 providing organization in writing, and it will be effective on the date notified except 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 no longer be protected by Federal privacy regulations.
- I understand I may see and copy 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 PATIENT Date Parent/Legal Guardian / Authorized Person Date

____________________________ ________ ____
Records Received By Date Relationship to Patient

FOR OFFICE USE ONLY

DATE REQUEST FILLED:___________________ BY:____
IDENTIFICATION PRESENTED:_______________ RECORDED IN MR: YES___ NO:___ INITIALS___ DATE:______