Shenandoah WOMEN'S HEALTHCARE
PROFESSIONAL CARE WITH A PERSONAL TOUCH
The Spa at Shenandoah

240 Lucy Drive,
Harrisonburg, VA 22801
Phone (540) 438-1314
Fax (540) 438-0797
www.swhc.net

Authorization for Release of Medical Information

_____ _____
(Print Patient's Full Name) **Date of Birth (MM/DD/YYYY)**

_____ _____
(Street Address) **Phone (home or cell)**

_____ _____
(City, State, Zip Code) **Phone (work)**

I, _____, hereby authorize the use or disclosure of my health information to the following individual or organization. If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instruction:

INFORMATION TO BE RELEASED TO:

_____
Name (Physician, hospital, agency, etc.)

_____
Street Address City, State, Zip Code

_____
Phone Number Fax Number

INFORMATION TO BE RELEASED FROM:

_____
Name (Physician, hospital, agency, etc.)

_____
Street Address City, State, Zip Code

_____
Phone Number Fax Number

The information to be used and disclosed as follows:

(Please include dates where appropriate)

☐ Complete Health Records: _____ ☐ Laboratory Results: _____
☐ Office Visits: _____ ☐ Ultrasounds: _____
☐ Pathology Reports: _____ ☐ Operative Reports: _____
☐ Other: _____

Purpose of Disclosure:
☐ Personal ☐Insurance ☐Transferring Care ☐Attorney ☐Exchange of Information
☐Other/Specify: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to medical record contact person. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality regulations.

_____ _____
Signature of Patient or Legal Representative **Date**

Office Use Only:
Faxed by: _____
Date: _____ Initials: _____