FAMILY PRACTICE ASSOCIATES of CHESTERFIELD
13911 ST FRANCIS BLVD #101 MIDLOTHIAN, VA 23114
PH 804-423-9913 FAX 804-423-9929

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

________________________________ (Print Patients Full Name)
________________________________ Birth Date (Mo/Day/Yr)

________________________________ (Street Address)
________________________________ Social Security Number

________________________________ (City, State, Zip Code)
________________________________ Phone (Home)

________________________________ (Parent/Guardian if Patient<18 yrs)
________________________________ Chart #

At the request of the individual, I ____________________ (Patients Name), do hereby authorize *FAMILY PRACTICE ASSOC*

to, __________ **RELEASE TO** or __________ **OBTAIN FROM (check one)** the following records:

SERVICE DATES ____

_____LAST TWO YEARS _____PATHOLOGY REPORTS _____ LABORATORY REPORTS _____ENTIRE CHART
_____OFFICE NOTES _____RADIOLOGY REPORTS _____ IMMUNIZATION ONLY

___ **I do** ___**I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), STD's, Adoption, genetic tests, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: OR OBTAIN FROM

____
Name of Company/Agency/Facility/Person

____
Street address

____
City, state, zip

_______ ***CHECK HERE*** *for e-Delivery to patient's email (fee is same for this service less postage & handling)*

________________________@________________________

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____LEAVING PRACTICE
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____RELOCATION/MOVING
OTHER (SPECIFY)____

Please provide current telephone number in the event we need to contact you: ____________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: **Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia Rates are pgs 1-50 at $0.50 per pg, pgs 51+ at $0.25 per pg. plus postage & handling. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.**

________________________________ ____________________
Signature of individual or guardian or **Date**
Personal Representative of patient's estate Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE___ LAB_____EKG_____PATH____ ____________________