AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

13911 St Francis Blvd, Ste 101 Midlothian, Va 23114
PH: 804-423-9913 FX: 804-423-9929

PATIENT NAME: _____ **DATE OF BIRTH**: _____
[Please Print Full Name]
Last 4 of SOCIAL SECURITY NUMBER: _____ **DAY PHONE**: _____

Patient Address: STREET: _____ **CITY**: _____ **STATE**: ____ **ZIP**: _____
[Need Complete Address to be Valid]
Authorize: Family Practice Associates of Chesterfield_____

Records to be Released to: _____ Records to be Obtained from:_____
Information Requested: (Select from options below)

- ☐ Entire Record
- ☐ Office Visit Notes
- ☐ Laboratory Results
- ☐ Pathology Reports
- ☐ X-rays or Imaging Report(s)
- ☐ Other (be specific): _____
- ☐ Immunization Records
- ☐ Abstract (Office Notes/Labs/Reports)

Method of Release:

Facility/Provider/Person to Receive Information: _____
[Name of Facility/Provider/Person to Disclose Health Information to]

☐ **Mailed to: STREET: _____ CITY: _____ STATE: ____ ZIP: _____**
or [Need Complete Mailing Address to be Valid]
☐ **eDelivered by Datavant to patient email address (records only): _____**
[Please Provide Patient Email Address if Requesting Electronic Delivery]

Purpose of Disclosure:

- ☐ Continuity of Care
- ☐ Insurance
- ☐ Litigation
- ☐ Worker's Compensation
- ☐ Disability Determination
- ☐ Personal
- ☐ Other (Please specify): _____

Authorization to Release Information:

1. **I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse unless otherwise specified below in Special Instructions:**

Special Instructions, if any: _____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the facility/provider listed above.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility/provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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. **Unless otherwise revoked, this authorization will expire 90 days from the date of signature. If applicable, insert another date or event of expiration: _____**

4. I understand that I will be given a copy of this authorization form upon request. **Furthermore, I understand that copying charges will be applied according to State/Federal Law.**

Signature of Patient or Legal Representative_____
DATE:

If signed by legal representative, relationship to patient: _____
[Please Provide Medical Power of Attorney if Individual is Over the Age of 18 and Not Signing this Authorization]

Department Use Only

Processed By: _____ **Date Processed: _____**

Pages Released: _____ **eRequest ID: _____**