Authorization for Release of Information

Patient Name: ______________________________

Last First MI Maiden or Other Name

Date of Birth: ____________ **SS# :** ______ ______ ______ **Medical Record# :** ____________

Address: ____________________ City: ____________ State: ______ Zip: ________

Day Phone: ______________ **Evening Phone:** ______________

I hereby authorize Southwest Virginia Community Health to release information to:

P.O. Box 729 Saltville VA 24370 Phone: (276) 496-4492 Fax: (276) 496-4839

Name: ______________________________

Address: ____________________ City: ____________ State: ______ Zip: ________

Phone: ______________ **Fax:** ______________

Information to be released, requested or exchanged:

Dates:

☐History and physical exams ____________
☐Progress notes ____________
☐Lab reports ____________
☐X-ray reports ____________
☐Other ____________

I specifically authorize the release/exchange of information relating to:
☐ Substance abuse (including alcohol/drug abuse)
☐ Mental Health (including psychological notes)
☐ HIV related information (AIDS related testing)

X

Signature of Patient/Parent Guardian Date

Purpose of Disclosure: ☐ Changing Physicians ☐Consultation/second opinion ☐Continuing care
☐Legal ☐ School ☐Insurance ☐Workers Compensation
☐Other (please specify): ______________________________

1. I understand that this authorization will expire on __________ days after I have signed the form.

2. 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.

3. 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.

4. I understand that if I am being requested to release this information by _________________________ (print name of provider) for the purpose of:

a. By authorizing this release of information, my health care and payment for my health care will not be effected if I do not sign this form.

b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

c. I have been informed that _________________________ (print name of provider) ☐will☐will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. I understand that in compliance with ____________________(print the state whose laws govern the provider) statute, I will pay a fee of $_________ (print the fee charged). There is no charge for medical records if copies are sent to the facilities for on going care or follow-up treatment.

Signature of Patient Date or Parent/Legal Guardian/Authorized Person Date

Records Received By Date Relationship To Patient

FOR OFFICE USE ONLY

Date Request Filled: ______________ By: ______________

Identification Presented: Fee Collected: $