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 from my medical records as indicated below to:

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Information To Be Released:

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

I specifically authorize the release 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.

_____ 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: Fee Collected: $