Authorization for Release of Health Information

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630

_____FRFP to Send Records
_____FRFP to Request Records

Patient's Name: _____ **Requested Date**: _____

Date of Birth: _____ **Medical Record Number**: _____

1. I authorize the use and/or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to disclose and to receive my health information:

Doctors Name: _____

Address: _____

City, State and Zip Code: _____

Phone Number: _____ **Fax**: _____

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

_____ Problem List/Core Data Sheet
_____ Medication List
_____ List of Allergies
_____ Immunization Record
_____ Most Recent History and Physical
_____ Most Recent Progress Note
_____ Consultation Reports
Other Physician/Hospital Records from:
_____ Laboratory Results Dated: _____ to _____
_____ X-Ray/Imaging Reports Dated _____ to_____
_____ Other _____

4. I understand that the information in my health record may include information relating to 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.

5. The information may be disclosed to or from the following individual or organization:

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630
Phone: 540-631-3700
Fax: 540-635-1673

For the purpose of: Continuity of Care/Coordination of Services

Are you transferring care? _____ If yes, Why: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that 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 on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 (one) year.

7. 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. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

If I have questions about the disclosure of my health information, I can contact the practice privacy officer and/or Roger Westfall, MD.

Signature of Patient or Guardian: _____

Relationship to Patient _____ Date: _____