Mount Vernon Primary Care Associates, PLLC
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Alexandria, VA 22306
Office (703) 799-4000 Fax (703) 799-4569

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF INFORMATION

PRINT PATIENT'S FULL NAME	PATIENT'S DATE OF BIRTH (MM/DD/YYYY)
PATIENT'S STREET ADDRESS	CITY, STATE, ZIP CODE
PATIENT'S PHONE NUMBER	ALTERNATE PHONE NUMBER

I, _____, do hereby authorize Mount Vernon Primary Care Associates to release:

____ ALL DATES OR ____ SPECIFIC DATES FROM _____ TO _____

____ ALL RECORDS ____ MVPCA OFFICE NOTES ____ HOSPITAL DISCHARGE SUMMARIES

____ RADIOLOGY REPORTS ____ PATHOLOGY REPORTS ____ LABORATORY REPORTS

____ HISTORY & PHYSICAL ____ OPERATIVE NOTES ____ EKG

PURPOSE OF DISCLOSURE (PLACE AN X):

____REFERRAL TO SPECIALIST ____INSURANCE REQUEST ____WORKERS COMP REQUEST

____LEGAL REQUEST ____DISABILITY REQUEST ____PERSONAL REQUEST

____ CHANGE OF DOCTOR ____CONTINUNING CARE

AUTHORIZE RELEASE OF INFORMATION: ____TO or ____FROM (CHECK ONE)

Name of Company/Agency/Facility/Person
Street Address
City, State, Zip

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 is authorized is furnished may not condition its treatment of me on whether or not I sign this authorization.

I hereby understand that by signing this form I am giving authorization to release information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ _____

SIGNATURE OF PATIENT /GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE

DATE

*****COPIES OF YOUR PROTECTED HEALTH INFORMATION ARE MADE AND INVOICED BY OUR BUSINESS ASSOCIATE PARTNER, HEALTH PORT, INC: 120 BLUEGRASS VALLEY PARKWAY, ALPHARETTA, GA, 1-800-464-0035 OR 1-800-367-1500 M-F 8AM-6PM.**

Print Form