medicalassociates
Adult Primary Care in Central Virginia

Authorization to Release Medical Records

Patient Name: _____MRN:_____
Date of Birth: _____ Physician: _____

This authorizes Medical Associates of Central Virginia to provide a copy, summary, or narrative of my medical records as indicated by the checkmark (s) below, or otherwise release confidential information.

Complete records
Records of care from the following dates:_____
Records concerning the following conditions:_____
Other, please specify:_____

The reasons or purposes for this release of information are as follows:

_____
_____
_____
_____
_____

Are you (the patient) transferring out of the Practice? _____YES OR _____NO (PLEASE INITIAL).

HIV/AIDS (If Applicable) I consent to the release of any positive or negative test result for AIDS or HIV Infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial: _____ Date: _____**

Release to the following person (s):

Name: _____
Street: _____
City: _____State:_____Zip:_____
Phone: _____ Fax: _____

Expiration Date: _____ or Expiration Event as detailed below:

I understand that Medical Associates of Central Virginia will provide this information within 15 days from receipt of request and that **a fee for preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.**
I understand that I may revoke this authorization in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
I understand that refusal to sign this authorization will not in any way affect my treatment.
I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosures bye the recipient and no longer protected by Federal or State Law.

Patient Signature: _____ Date: _____
Authorized Representative: _____ Relationship to Patient: _____