1867 Amherst Street Winchester VA 22601 540-667-8724 FAX 540-662-5638

Authorization for Release of Medical Information

_____ _____

Print patient full name | Birth date (Month/Day/Year)

_____ _____

Street address | Social security number

_____ _____

City, state, zip code | Phone

_____

Parent/Guardian if patient is under 18yrs.

I _____, do hereby authorize **Amherst Family Practice** to release:
(Patient name)

Dates of_____

___Discharge Summary ___Pathology Reports ____Operative Notes ___Immunizations only
____History & Physical ___Laboratory Reports ___Radiology Reports ___Entire Chart
____Progress Notes ___ECG/EEG/CARDIO CATH ___Last 3 years ___Other_____

_____ I do _____I do NOT authorize release of information related to STD, AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____Referral to Specialist _____Insurance _____Workers Comp _____Leaving Practice
_____Legal Investigation _____Disability Determination _____Personal
_____Relocation/Moving _____Other_____

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

_____ _____

Signature of individual or guardian or personal representative | Date
Of patients estate////power of attorney must be attached

NOTE: Virginia Law permits a charge for personal copy/transfer of your records. Health Port has been contracted to provide this service and will invoice you directly. Virginia State rates apply. Pages 1-50 are $.50 per page. Pages 50+ are $.25 per page plus required postage. PRE-PAYMENTS IS REQUIRED PRIOR TO RELEASE OF RECORDS.

MEDICAL INFORMATION RELEASED

ENTIRE _____ LAB_____ EKG_____ _____
DS_____ EKG_____ IMMUNE_____ ROI SPECIALIST
OP_____ X-RAY_____ OTHER_____ _____
HP_____ PATH_____ DATE

Rev: 2010-10