Fairfax Family Practice Centers
12011 Lee Jackson Memorial Highway, Suite 504 Fairfax, VA 22033 (703) 391-2030

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please note that you will receive an invoice from HealthPort that must be paid before records can be sent.
Medical records will be sent by mail ONLY.

_____ _____
Print patient's full name DOB (MM/DD/YY)

_____ _____
Street Address Primary Phone Number – Home/Mobile/Work

_____ _____
City, State, Zip Code Secondary Phone Number – Home/Mobile/Work

Location: ___ Fairfax (next to FairOaks Hospital) ___ Gainesville ___Herndon ___ Lorton
___Manassas ___ South Riding ___ Town Center ___ Vienna

At the request of the individual, I _____, do hereby authorize Fairfax Family Practice Centers to release:
Patient's Name

Dates of _____

___ Discharge Summary	___ Pathology Reports	___ Emergency Reports	___ Electronic Summary
___ History & Physical	___ Laboratory Reports	___ All Records	Summary offered by
___ Progress Notes	___ Radiology Reports	___ Other	Fairfax Family Practice Centers
___ Operative Notes	___ ECG/EEG/Cardiac Cath	_____	See example on second page

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infections, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug use.

Withhold Specific Dates of: _____

INFORMATION RELEASE TO:

_____
Name of Company/Agent/Facility/Person

____ CHECK HERE for e-Delivery

____ Additional Form required

_____
Street Address

_____
City, State, Zip Code

PURPOSE OF DISCLOSURE:

___ Referral to Specialist	___ Insurance	___ Personal	___ Leaving Practice
___ Legal Investigation	___ Workers Comp	___ Continuing Care	___ Disability Determination

I hereby authorize disclosure of 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 will not affect 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 who this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian (if person is under 18 years of age) or personal representative of patient's estate Date

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will bill you directly. VA State rates apply. Pages 1-50 $ 0.50/page. Pages 51+ are $0.25 each plus the cost of first class postage.

FOR USE BY HEALTHPORT REPRESENTATIVE ONLY

__ ENTIRE	__ LAB	__ EKG	__ DS	_____
__ IMMUNE	__ OP	__ X-RAY	__ OTHER	ROI SPECIALIST
__ HP	__ PATH			

Chart Summary

Our practice can provide an electronic summary of your records in a list format. Please select the following chart items you are interested in:

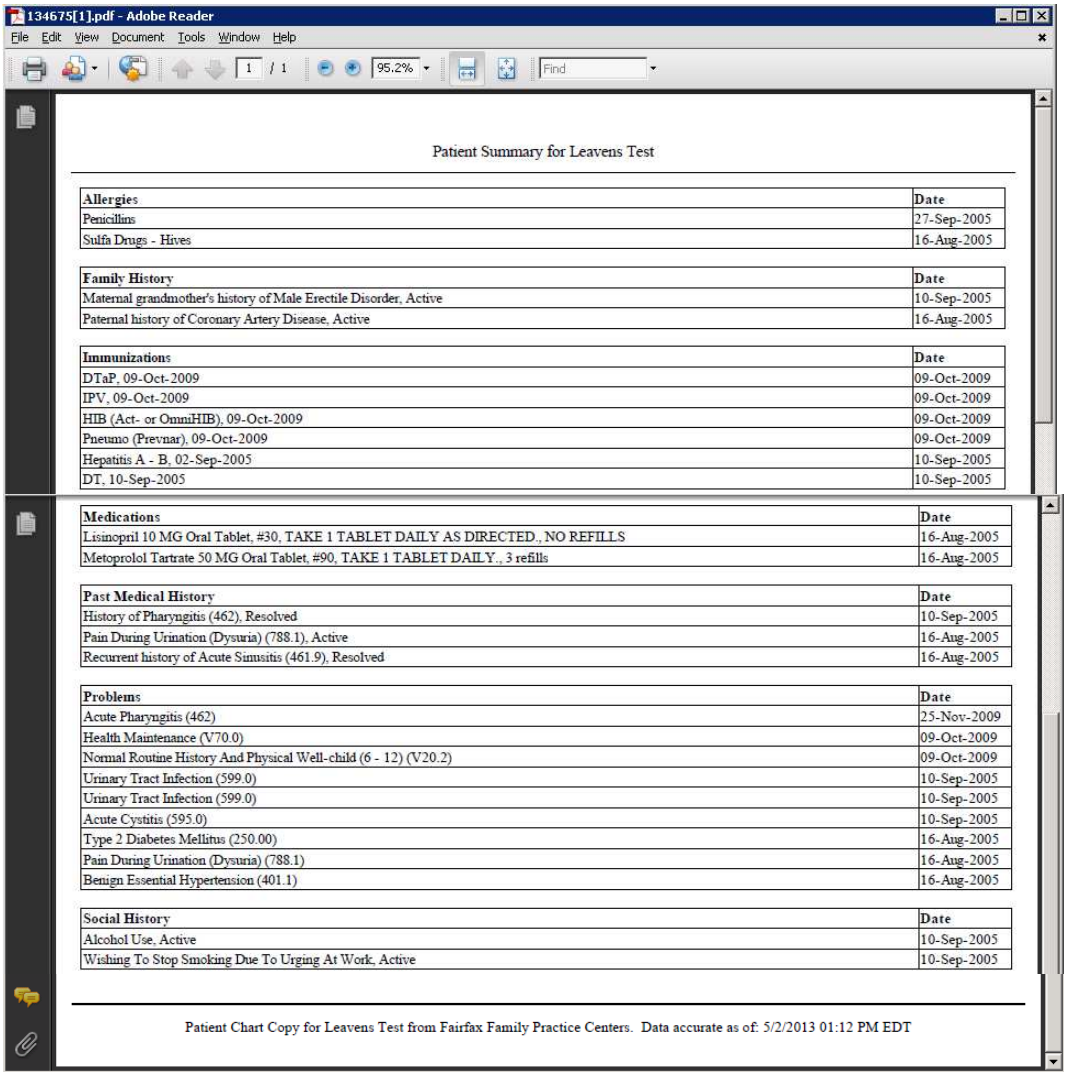
_____ALL	_____Medications
_____Active Problems	_____Past Medical History
_____Allergies	_____Results
_____Family History	_____Social History
_____Immunizations	_____Vitals

Please select the following method of how you would like to receive the CD:

_____Intuit Patient Portal Account (Register for free on our website) – free of charge

_____Pick up in the office - $ 5.00

_____By mail – $ 12.00 charges incur for packaging, postage and signature confirmation



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Patient Summary for Leavens Test

Allergies	Date
Penicillins	27-Sep-2005
Sulfa Drugs - Hives	16-Aug-2005

Family History	Date
Maternal grandmother's history of Male Erectile Disorder, Active	10-Sep-2005
Paternal history of Coronary Artery Disease, Active	16-Aug-2005

Immunizations	Date
DTaP, 09-Oct-2009	09-Oct-2009
IPV, 09-Oct-2009	09-Oct-2009
HIB (Act- or OmniHIB), 09-Oct-2009	09-Oct-2009
Pneumo (Prevnar), 09-Oct-2009	09-Oct-2009
Hepatitis A - B, 02-Sep-2005	10-Sep-2005
DT, 10-Sep-2005	10-Sep-2005

Medications	Date
Lisinopril 10 MG Oral Tablet, #30, TAKE 1 TABLET DAILY AS DIRECTED., NO REFILLS	16-Aug-2005
Metoprolol Tartrate 50 MG Oral Tablet, #90, TAKE 1 TABLET DAILY., 3 refills	16-Aug-2005

Past Medical History	Date
History of Pharyngitis (462), Resolved	10-Sep-2005
Pain During Urination (Dysuria) (788.1), Active	16-Aug-2005
Recurrent history of Acute Sinusitis (461.9), Resolved	16-Aug-2005

Problems	Date
Acute Pharyngitis (462)	25-Nov-2009
Health Maintenance (V70.0)	09-Oct-2009
Normal Routine History And Physical Well-child (6 - 12) (V20.2)	09-Oct-2009
Urinary Tract Infection (599.0)	10-Sep-2005
Urinary Tract Infection (599.0)	10-Sep-2005
Acute Cystitis (595.0)	10-Sep-2005
Type 2 Diabetes Mellitus (250.00)	16-Aug-2005
Pain During Urination (Dysuria) (788.1)	16-Aug-2005
Benign Essential Hypertension (401.1)	16-Aug-2005

Social History	Date
Alcohol Use, Active	10-Sep-2005
Wishing To Stop Smoking Due To Urging At Work, Active	10-Sep-2005

Patient Chart Copy for Leavens Test from Fairfax Family Practice Centers. Data accurate as of: 5/2/2013 01:12 PM EDT

HealthPort

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requestor Name		
	First	**Last**
Street Address		
	Street	**Suite / Apt #**
	City	**State / Zip Code**

Email Address for Record Delivery																							

Medical Records Requested

Patient Name			
	First	**MI**	**Last**
Date of Birth			
Date of Service			
	From	**To**	

Please provide me with the medical records described above through the HealthPort eDelivery online service.

I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date _____