

LOUDOUN MEDICAL GROUP
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient full name

_____/_____/_____
Birth date

Street address

_____-_____-_____
Social Security Number

City/State/Zip

(_____)_____-_____
Home phone number

At the request of the individual, I _____, do hereby authorize

_____ to release:

- | | | |
|---|---|--|
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other Infectious Disease | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | _____ |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> ECG/EEG/Cardiac Cath | _____ |

I do I do NOT authorize release of 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.

PLEASE RELEASE INFORMATION TO:

Name of Company/Agency/facility/Person

Street Address

City/State/Zip

PURPOSE OF DISCLOSURE:

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Referral to specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change of Doctor/Provider |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability determination | <input type="checkbox"/> Personal | <input type="checkbox"/> Continuing care |
- Other(please specify)_____

Please provide the best telephone number in the event we need to contact you (home or work or cell) (_____)_____-_____

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 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 of patient's estate**

Date

NOTE: There may be a charge for a personal copy or the permanent transfer of your records as follows: a \$10 base fee, \$.50 per page for pages 1-50, then \$.25 for any pages over 50.