PIEDMONT FAMILY • PRACTICE
ScanSTAT™ TECHNOLOGIES

493 Blackwell Rd Suite 202, Warrenton, VA 20186 -- -- -- Fax (540) 341 – 0922 -- -- -- Phone (540) 347 - 4400

Authorization for Release/Disclosure of Medical Information

_____
(Print Patient's Full Name) (Date of Birth) (Social Security Number)

_____
(Street Address) (City) (State) (Zip Code)

_____
(Phone Number) (Parent/Guardian Name if Patient is <18 yrs old)

At the request of the individual, I, _____, do hereby authorize **Piedmont Family**
(Patient's Name)
Practice to release the following:

____ Last two years	____ Entire Chart/All Records	____ Pathology Reports
____ Office Notes	____ Laboratory Results	____ Immunization Record
____ Radiology Reports	____ Itemized Statements	____ Consultations
____ All information between _____ (Date Range)		____ Other

Circle one: I do / I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), STDs, Adoption, genetic tests, psychiatric care, and/or psychological assessment, and treatment for alcohol and/or drug abuse.

The information indicated above may be released to:

_____
(Name of Practice/Person/Agency/Facility/Company) (Fax Number) (Phone Number)

_____
(Mailing Address) (Apt, Suite, or PO#) (City) (State) (Zip Code)

Purpose of Release: ____ Referral to Specialist ____ Insurance ____ Workers Comp ____Personal
____ Leaving Practice _____ Legal Investigation ____ Other (specify): _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state and federal regulations. I understand that once the above information is disclosed, it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Piedmont Family Practice in writing. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment, enrollment, or eligibility for benefits. I understand that I may ask for a copy of this authorization upon my signature. I hereby authorize ScanSTAT to release information on behalf of Piedmont Family Practice. I hereby release Piedmont Family Practice and/or ScanSTAT from any liability which may result from this disclosure of confidential medical information or which may arise because of the use of information contained in the information released. I authorize that this information may be faxed when applicable. I agree to pay copy charges if applicable.

_____
(Patient's Signature) (Date)