PIEDMONT FAMILY PRACTICE
493 BLACKWELL RD #202 WARRENTON, VA 20186
PH 540-347-4400

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name) _____ Birth date (Mo/Day/Yr) _____

(Street address) _____ Social security number _____

(City, state, zip code) _____ Phone (Home) _____

(Parent/Guardian if Patient<18 yrs) _____ Chart # _____

At the request of the individual, I _____ (Patients Name), do hereby authorize *PIEDMONT FAMILY* to release:

SERVICE DATES _____

_____LAST TWO YEARS _____PATHOLOGY REPORTS ____ENTIRE CHART
_____ OFFICE NOTES _____LABORATORY REPORTS ___ SPECIFIC TEST_____
_____ IMMUNIZATIONS ONLY _____RADIOLOGY REPORTS ____OTHER_____

__I do ___I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), STD's, Adoption, genetic tests, 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

_____ *CHECK HERE for e-Delivery to patient's email*
_____@_____

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____LEAVING PRACTICE
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____RELOCATION/MOVING
OTHER (SPECIFY)_____

Please provide current telephone number in the event we need to contact you: _____

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.

NOTE: Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia Rates are pgs 1-50 at $0.50 per pg, pgs 51+ at $0.25 per pg. plus postage & handling. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate Power of Attorney Must Be Attached **Date**

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE___ LAB_____EKG_____PATH_____
DS_____ EKG_____ IMMUNE___H&P
OP_____ X-Ray_____ OTHER_____

_____
ROI SPECIALIST DATE