FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

2761 Jefferson Davis Highway, Ste 101

Stafford, VA 22554

P: 540-602-0870 F: 540-318-6680

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME: _____ DOB: _____ PHONE #: _____

PLEASE OBTAIN INFORMATION FROM:

_____

NAME OF PROVIDER/CLINIC/ORGANIZATION

_____

STREET ADDRESS

_____

City, State, Zip Code

Phone: _____ Fax: _____

PLEASE RELEASE INFORMATION TO:

_____

NAME OF PROVIDER/CLINIC/ORGANIZATION

_____

STREET ADDRESS

_____

City, State, Zip Code

Phone: _____ Fax:_____

Delivery Method (How would you like the records sent?):

___ Email ___Paper Copy ___Fax

I authorize the following information to be disclosed: (Please indicate all that apply)

* HIV/STD, Psychiatric/Mental Health records will not be released unless specifically noted.

___Entire Record ___HIV Record ___Billing Records ___Immunization Record ___STD Record
___Other ___Lab Results ___Psychiatric/Mental Health

___ Specific Date (s) _____

FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

REASON for disclosure of health information: (Please indicate all that apply)

___Transferring to new physician ___Job ___Personal Use ___School
___Insurance ___Moved ___Continuing Care ___Legal/Attorney

___Convenience ___Other

ADDITIONAL HIPAA INFORMATION:

• I understand that my original records will not be released, only copies.

• I acknowledge that VA law allows for reasonable copy fees: Up to $ 10.00 for labor, supplies and postage costs PLUS $0.50 per page for the first 50 pages and $0.25 a page thereafter.

• I understand that my refusal to sign this authorization will not affect my ability to receive treatment.

• I understand that I have the right to withdraw this authorization by submitting a written request, except where actions have already been taken on the basis of this release.

_____ _____

Signature of Patient/Representation Date

_____ _____

Print Name of Patient's Representative Relationship To Patient