Virginia Center For Medicine

43490 Yukon Drive, Suite 210
Ashburn, Virginia 20147

AUTHORIZATION FOR USE OF
DISCLOSURE OF PATIENT
HEALTH INFORMATION

Patient Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________
City: ______________________ State: __________
Zip Code: __________ Ph Number: __________________

Virginia Center for Medicine may release this information to: ☐ Check if same as above
Recipient Name: ______________________________
Address: ______________________________
City: ______________________ State: __________ Zip Code: __________________
Ph Number: ______________________ Fax Number: ______________________________

Enter the date range of the records to be released (check one):
☐ Last two years
☐ From: ______________ To: ______________

Identify the health information to be released:
☐ Office Notes ☐ Lab Results ☐ Radiology Reports ☐ Immunization ☐ Other: __________________

Medical records may contain references to behavioral health, substance abuse and sexually transmitted conditions. Check the boxes below if you want this release to exclude the following, otherwise this information will be included.
☐ Behavioral health records ☐ Substance abuse records ☐ Records related to sexually transmitted conditions

Record Delivery Preference: ☐ Pickup ☐ Mail ☐ Fax

FEES: A reasonable cost-based fee may be charged for copying and transfer of records.
DURATION: Authorization shall remain in effect for six months from the date of signature below.
REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request. Your cancellation will not affect information that was released prior to receipt of the written request.
REDISCLOSURE: Once this information is released, it may not be protected under federal privacy (HIPAA). State or other federal law may require the recipient to obtain your authorization before future disclosure.

Virginia Center for Medicine may not condition treatment, payments, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. A copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have the right to a copy of this completed authorization.

______________________________ ______________ ______________________________
Signature Date If personal representative, print name/relationship