Family Medicine Center

1201 Lake James Drive, Suite 200 ◦ Virginia Beach ◦ Virginia ◦ 23464 ◦ Phone: 757-523-0022

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Full Name (Print) _____

Date of Birth (Month, Day, Year) _____

Street Address _____

City_____ State _____ Zip _____

I (patient or legal guardian) _____, do hereby authorize **Family Medicine Center** to release the following Confidential Health Care Information:

☐ **All RECORDS** or Specify Below

☐ Patient Intake Forms	☐ Office Progress Note	☐ Radiography Report
☐ Lab Reports	☐ EKG	☐ Psychiatric / Psychological Care
☐ Consultation Report	☐ HIV / AIDS STD Test	☐ Pathology
☐ Alcohol / Drug Abuse	☐ Drug Screen Report	☐ Emergency Room
☐ Billing / Insurance Records	☐ Discharge Summary	
☐ Hospital Record	☐ History / Physical	

☐ Date of Service Beginning: _____ Ending: _____

INFORMATION RELEASE TO:

Name of Physician/ Hospital / Agency / _____

Street Address _____

City _____State _____ Zip _____

Phone: _____ FAX _____

PURPOSE OF DISCLOSURE

☐ New Provider	☐ Legal Investigation	☐ Disability Determination
☐ Workers Compensation	☐ Personal	☐ Other Specify _____

- I hereby authorize disclosure of health information for the above named patient.
- This authorization is valid for 12 months from the date of signature.
- I understand I may cancel this request with written notification but it will not affect any information already released.
- I understand that the information may be re-disclosed by the facility or individual receiving it and would then be no longer protected by federal regulation.
- The above named provider may not condition treatment on me on my signing this authorization.
- ***There will be a charge for copying records $0.50 per page for the first 50 pages and $0.25 per page thereafter.***

Patient (legal guardian if patient is a minor) Signature _____ Date _____

THIS FORM MUST BE COMPLETE IN ORDER TO PROCESS RECORDS