Family Practice Specialists of Richmond, PC
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Birth Date (Mo/Day/Yr)

_____ _____
Street Address Social Security Number

_____ _____
City, State, Zip Code Phone

Physician/Facility to contact: _____ Phone: _____Fax: _____

At the Request of the individual, I _____, hereby authorize _____

to release:

___Progress Notes ___Pathology Reports ___ALL RECORDS
___Other Doctors Notes ___Laboratory Reports ___Immunizations
___OB/GYN Notes ___Radiology Reports ___Other _____
___Hospital Notes ___ECG/EEG/Cardiac Cath _____

___I do ___I do NOT **Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.**

INFORMATION RELEASE TO: **Family Practice Specialists of Richmond, PC**
3742 Winterfield Road
Midlothian, VA 23113
Phone: 804-330-3335
Fax: 804-320-2717

PURPOSE OF DISCLOSURE:

___Referral To Specialist ___Insurance ___Workers Comp
___Legal Investigation ___Disability Determination ___Personal

OTHER (Specify):_____

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 affect 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.

_____ _____
Signature of Individual/Guardian/Personal Representative of Patient's Estate **Date**