Family Practice Specialists of Richmond, PC
3742 Winterfield Rd. Midlothian, VA 23113
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 _____

At the request of the individual, I _____, hereby authorize **Family Practice Specialists of Richmond, PC** to release:

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

___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.**

RELEASE INFORMATION TO:

_____
NAME (PHYSICIAN, HOSPITAL,AGENCY, ETC...)

_____
STREET ADDRESS

_____
CITY/STATE/ZIP

PURPOSE OF DISCLOSURE:

___Referral To Specialist
___Legal Investigation
___Insurance
___Disability Determination
___Workers Comp
___Personal

OTHER (Specify):_____

*****NOTE: THERE WILL BE A CHARGE FOR RECORDS IN ACCORDANCE WITH THE VA CODE 8.01-413 $0.50(PER PAGE UP TO 50 PAGES) ADDITIONAL $0.25 PER PAGE (FROM PAGE 51 & UP) + ACTUAL POSTAGE. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY WITH PRE BILL INVOICE. ONCE INVOICE HAS BEEN PAID THE MEDICAL RECORDS WILL BE PRINTED AND MAILED. *****

I have read the policy and understand the charges associated with the release of medical records. I accept financial responsibility.

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

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**