AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Virginia Institute of Family Medicine - Patient Authorization and Medical Records Request

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____

Address: _____

PROVIDER/FACILITY AUTHORIZED TO RELEASE RECORDS

Provider/Facility Name: _____

Phone: _____ **Fax:** _____

Address: _____

RELEASE RECORDS TO

Virginia Institute of Family Medicine TO: ERICA. M ALLEN WINSLOW MD, MPH

Phone: 703 522- 8009 **Fax:** 703 522- 8014

Secure Email: Admin@VAinstituteFM.com **Address:** 3720 Joseph Siewick Drive Suite 304; Fairfax, VA 22033

RECORDS ~~REQUESTED~~

- ☐ Complete Medical Record
- ☐ Office Notes
- ☐ Medication List
- ☐ Immunization Records
- ☐ Lab Results
- ☐ Imaging Reports
- ☐ Consultation Reports
- ☐ Hospital Records
- ☐ Mental Health Records

Other: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PURPOSE OF DISCLOSURE

☐ Continuity of Care / Treatment ☐ Transfer of Care ☐ Insurance

☐ Personal Use **Other:** _____

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize the release of the medical information identified on this form to Virginia Institute of Family Medicine.
I understand this authorization is voluntary and may be revoked in writing at any time, except to the extent action has already been taken in reliance upon it. Unless otherwise revoked, this authorization expires one (1) year from the date signed below.

SENSITIVE INFORMATION AUTHORIZATION - INITIAL IF APPLICABLE

Mental Health Records: _____ **HIV/AIDS Information:** _____

Substance Use Treatment Records: _____

HIPAA CONFIDENTIALITY STATEMENT

This information has been disclosed from records protected by federal and state confidentiality laws, including HIPAA.
This information may not be further disclosed without the specific written consent of the patient or as otherwise permitted by law.

PATIENT SIGNATURE / AUTHORIZATION he original.

Patient Signature:

PATIENT SIGNATURE / AUTHORIZATION

By signing my name below, I authorize this release of information.

Patient Signature: _____ **Date:** _____

Printed Name: _____

If signed by Personal Representative:

Representative Name: _____ **Relationship:** _____

Authority to Act: _____