Family Physicians of Old Town Fairfax

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_____ _____
(Print Patients full name) Birth date (Mo/ Day/ Year)

_____ _____
(Street address) Email

_____ _____
(City, State, zip code) Phone (Home)

_____ _____
(Parent/Guardian if Patient is under 18) Phone (Cell)

At the request of the individual, I _____, do hereby authorize _____ to release:

SERVICE DATES REQUESTED:_____

_____**LAST THREE YEARS** _____ PATHOLOGY REPORTS _____IMMUNIZATIONS ONLY
_____ENTIRE CHART _____LABORATORY REPORTS _____HISTORY & PHYSICAL
_____PROGRESS NOTES _____RADIOLOGY REPORTS _____ 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.

INFORMATION RELEASED TO: _____
Name of Company/Agency/Facility/Person

_____
Street address, city, state, Zip code

_____ _____
Phone number Fax number

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____LEAVING PRACTICE
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____RELOCATION/MOVING
_____ 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 effect 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. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: **VIRGINIA LAW PERMITS A CHARGE FOR PERSONAL COPY/TRANSFER OF YOUR RECORDS.**
PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS

_____ _____
Signature of Individual or guardian or Date
Personal Representative of patient's estate **Power of Attorney Must Be Attached**.

Released by: Family Physicians of Old Fairfax _____
Date