MEDICS USA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patient's full name) _____ Birth date (Month/Day/Year) _____

(Street Address) _____ Social Security Number _____

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

At the request of the individual, I _____ (Patient's Name), do hereby authorize _____ (Name of Facility) to release:

DATES OF _____

_____DISCHARGE SUMMARY	_____PATHOLOGY REPORTS	_____EMERGENCY REPORTS
_____HISTORY & PHYSICAL	_____LABORATORY REPORTS	_____ALL RECORDS
_____PROGRESS NOTES	_____RADIOLOGY REPORTS	_____OTHER_____
_____OPERATIVE 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: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP	_____LEAVING PRACTICE
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL	_____CONTINUING CARE

_____OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

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. 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.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: SUBJECT TO THE PROVISIONS OF THE HEALTH GENERAL OF THE VIRGINIA STATE CODE, FOR A COPY OF MEDICAL RECORDS REQUESTED BY A PERSON OR ANY OTHER PERSONS, A HEALTH CARE PROVIDER MAY CHARGE A FEE FOR COPYING, FAXING, AND MAILING NOT EXCEEDING .50 CENTS FOR EACH PAGE OF THE MEDICAL RECORDS. IN ADDITION TO THE FEE CHARGED, A HEALTH CARE PROVIDER MAY CHARGE A PREPARATION FEE NOT TO EXCEED $15.00 FOR MEDICAL RECORD RETRIEVAL AND PREPARATION.
$15.00 + (TOTAL PAGES x .50) = TOTAL AMOUNT DUE

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