

ATWOOD FAMILY MEDICAL CENTER
CHESAPEAKE EXECUTIVE FAMILY CARE

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Daytime Phone/Cell Number** _____

I authorize: Atwood Family Medical Center
108 Knell Ridge Boulevard, Suite 100
Chesapeake, VA 23320

to: **obtain** information from **release** information to

Name of Physician/Facility

FAX Number

Address

Phone Number

City/State/ZIP

Purpose of the use or disclosure:

At the request of the individual (patient initiated authorization) Other, please specify _____

Reason for request:

Transferring to new primary care physician Records requested by specialist office
 Change of insurance (to non-participating) Other (please specify) _____
 Moving out of the area
 Unsatisfied with patient care (please elaborate) _____

Information to be provided:

Date(s) of Treatment _____

Send past 3-years of medical record Laboratory Reports Medications
 History and Physical Pathology Reports Consultations
 Progress/Office Notes Immunization Record X-ray Reports
 Other (Specify) _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

Yes, disclose this information _____
No, DO NOT disclose this information _____

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.

Redisclosure: I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Regulations.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization. AFMC and its staff are hereby released and discharged from any liability. I will hold AFMC and its staff harmless for complying with this authorization to release medication information.

Signature of Patient or Representative

Date

Printed Name of Patient or Representative

Relationship to Patient

PLEASE NOTE – FEDERAL AND STATE LAWS PERMIT A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS. YOU MAY BE REQUIRED TO PRE-PAY FOR THE COPIES; IF NOT, THEN YOUR COPIES WILL BE MAILED ALONG WITH AN INVOICE.

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Office Use Only

Received

Processed By

Date