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/Sate/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
[ ] Change of insurance (to non-participating)
[ ] Moving out of the area
[ ] Unsatisfied with patient care (please elaborate) _____
[ ] Records requested by specialist office
[ ] Other (please specify) _____

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.

Office Use Only

_____ _____ _____
Received Processed By Date