Authorization for Release of Medical Information

Patient Name: **Patient #:**

Social Security # (last 4 digits): **Date of Birth:**

Please forward copies of requested records

Name:
Address:
City, State, & Zip:

Release the following:
_____Entire Health Record
_____Immunization Records Only
_____Specific Dates of Treatment: From_____to_____

_____Other _____

I am requesting that this protected information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

☐ This request is being made because I am transferring care to another primary care provider or leaving the area.

☐ This authorization shall remain in effect until _____ (up to 6 months) at which time this authorization expires.

☐ I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and / or substance abuse.

☐ I also authorize for the release of information regarding diagnosis and or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Nephrology Associates of Northern Virginia, attention Medical Release Correspondent, at the above address.

I hereby authorize Nephrology Associates of Northern Virginia to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS

Patient Name: **Phone:**

Patient Signature: _____ **Date:**

Legal Representative: _____ **Date:**

Relationship:

Witnessed by: _____ **Date:**