Virginia Women's Health Associates
Obstetrics, Gynecology, Infertility

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1800 Town Center Drive, Suite 220
Reston, Va. 20190
Office: 703-435-2555
Fax: 571-926-8910

_____ Print Patient full name

_____/_____/_____ Birth date

_____ Street address

_____-_____-_____ Social Security Number

_____ City/State/Zip

(_____)_____-_____ Home phone number

At the request of the individual, I _____, do hereby authorize
Name of Company/Agency/Person:_____Phone:_____Fax:_____
to release:

_____Discharge Summary
_____History & Physical
_____Progress Notes
_____Operative Notes
_____Pathology Reports
_____Laboratory Reports
_____Radiology Reports
_____ECG/EEG/Cardiac Cath
_____Emergency 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.

PLEASE RELEASE INFORMATION TO:

_____
Name of Company/Agency/facility/Person

_____
Street Address

_____
City/State/Zip

PURPOSE OF DISCLOSURE:
____Referral to specialist ____Insurance ____Workers Comp ____Change of Doctor/Provider
____Legal Investigation ____Disability determination ____Personal ____Continuing care
Other(please specify)_____

Please provide the best telephone number in the event we need to contact you (home or work or cell)(_____)_____-_____

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 many 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: There may be a charge for a personal copy or the permanent transfer of your records as follows: a $10 base fee, $.50 per page for pages 1-50, then $.25 for any pages over 50.