Patient First

MEDICAL RECORD #: _______-___________________
Center # Patient #

Authorization for Release of Information

PATIENT NAME: ____________________ ____________________ __________ ____________________
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ______-______-_________ LAST 4 DIGITS OF SS#: ______________________
MO DAY YR

I hereby authorize PATIENT FIRST or ______________________________ (Print Name of Provider) to release my medical record and/or items checked below to:

NAME: ____

ADDRESS: ____________________________CITY: ____________________STATE: ______ZIP: ____________

PHONE: ____________________________FAX: ____________________________

INFORMATION TO BE RELEASED: Date(s):

- ❑ Medical Record ______________________________
- ❑ X-rays ______________________________
- ❑ EKG ______________________________
- ❑ Itemized Statement ______________________________
- ❑ Other: ________________ ______________________________

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Insurance
❑ Continuing Care ❑ Legal ❑ School
❑ Workers Compensation ❑ At my request (You are not required to give a reason.)
❑ Other (please specify): ____

- I understand that if Patient First has requested this authorization, then I will get a copy of this form after I have signed it.
- I understand that this authorization will be valid for one year.
- I understand that I may revoke this authorization at any time by notifying Patient First in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information disclosed to the above individual or organization may be redisclosed by the recipient and may not be protected by Federal or State Privacy Rules.
- I understand that my right to receive medical services from Patient First will not be affected if I refuse to sign this authorization.
- I understand that if my record contains information related to substance abuse, HIV related information, sexually transmitted diseases, genetic testing results, and/or psychotherapy notes and other mental health information, that information will be released with my medical record, subject to and consistent with applicable State law requirements.

____ ________________
Signature of Patient/Legal Guardian/Personal Representative Date

____
If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so.

Instructions: Hand-deliver to any Patient First center, or mail or fax to:

Medical Records Department Fax #: 804-968-4269
Patient First
P.O. Box 5411
Glen Allen, VA 23058
Phone #: 804-822-4530