Family Healthcare of Fairfax, P.C.
3025 Hamaker Court Suite #350 Fairfax, VA 22031
Phone: (703) 573-6400 Fax: (703) 641-5821

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____________________ (Print Patient's Full Name)	____________________ (Birth Date Mo/Day/Yr)
____________________ (Street address)	____________________ (Social Security number)
____________________ (City, state, zip code)	____________________ (Home phone number) (Cell number)
____________________ (Parent/ Guardian signature if Patient < 18 years)	____________________ (e-mail address)

I ______________________________, do hereby authorize **Family Healthcare of Fairfax, P.C.** to release:
(Patient's Name)

SERVICE DATES REQUESTED: ______________________________

__ LAST THREE YEARS	__ PATHOLOGY REPORTS	__ IMMUNIZATIONS ONLY
__ HISTORY & PHYSICAL	__ LABORATORY REPORTS	__ ENTIRE CHART
__ PROGRESS NOTES	__ RADIOLOGY REPORTS	__ OTHER ____________
__ OPERATIVE NOTES	__ ECG/EEG/CARDIO CATH	____________________

__ 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.

INFORMATION RELEASED TO:

____
Name of Company/Agency/Facility/Individual

____
Street address

____
City, state, zip

PURPOSE OF DISCLOSURE:

__ REFERRAL TO SPECIALIST	__ INSURANCE	__WORKERS COMP	__ LEAVING PRACTICE
__ LEGAL INVESTIGATION	__ DISABILITY DETERMINATION	__PERSONAL	__ RELOCATION/MOVING

__ OTHER (SPECIFY) ______________________________

Please provide current telephone number in the event we need to contact you: ____________________

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 may not condition its treatment of me on whether or not I sign the authorization.

NOTE: Virginia Law permits a charge for personal copy/ transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS. (Pages 1-50 $.50 each, pages 51 and up $.25 cents each. Prices subject to change.)

______________________________ ____________________
Signature of Individual or Guardian or Personal Representative of Patient's Estate -Power of Attorney Must Be Attached **Date**

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE____ LAB_____ EKG ____
DS ____ IMMUNE ______ OP_____
HP ____ X-RAY ______ PATH ____
OTHER ____________________

____
ROI SPECIALIST

____
DATE

APPROVED BY: ____________________ **DATE:** ____________________ FHF11/12