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

(Patient's Full Name) _____

(Parent/ Guardian Name if Patient < 18 years) _____

(Street Address) _____

(Patient Birth date Mo/Day/Yr) _____

(City, State, Zip Code) _____

(Home Phone Number) _____ (Cell number) _____

(e-mail address) _____

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

SERVICE DATES REQUESTED: _____

__ COMPLETE RECORD
__ PATHOLOGY REPORTS
__ LABORATORY REPORTS
__ RADIOLOGY REPORTS
__ ECG
__ IMMUNIZATIONS ONLY

INFORMATION RELEASED TO: ____ SELF

_____
Name of Company/Agency/Facility/Specialist/Individual

_____
Street Address

_____
City, State, Zip

_____
Fax Number

Be sure to contact your insurance company and change your PCP!

PURPOSE OF DISCLOSURE:
_____LEAVING PRACTICE

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.

_____ _____
Signature of Individual or Guardian **Date**

_____ _____
Approved By **Date**