Centerville Family Practice, P.C.

PO Box 5275, Glen Allen, VA 23058
Phone: 804-708-9480 Fax 804-708-0865

Authorization for Release of Medical Information

Patient Name:	Date of birth:____/___/____ Mo/Day/Year	SSN:	Phone Number:
Address	City	State	Zip Code

I hereby authorize: (Hospital/Practice)_____
Phone:_____Fax:_____Address:_____
_____
disclosure/release of the medical information of the above named patient to:

Centerville Family Practice, P.C.

PO Box 5275, Glen Allen, VA 23058
Phone: 804-708-9480 Fax 804-708-0865

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 will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that Centerville Family Practice, P.C. may not condition its providing of heath care upon my authorization of this disclosure. I understand I have the right to receive a copy of this authorization.

Information to be released:	Dates:	Details:	Purpose of Disclosure
Discharge summary			○ Continuing Care ○ Change of Physicians ○ Consulting second opinion ○ Personal ○ Legal ○ School ○ Insurance ○ Workers Compensation ○ Other_____ _____ _____
History and Physical			
Operative Record			
Consultations			
Laboratory reports, Biopsy results			
X rays and Imaging Results			
Immunization Records			
Other			
Emergency Room records			

I understand that I am giving my permission to release information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing, testing or treatment of sexually transmitted infection, unless indicated in the following instructions:_____

Signature of Patient or Legal Representative of the patient_____
Name of Patient or Legal Representative:_____
Date signed_____