Authorization for Release of Health Information

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630

_______**FRFP to Send Records**
_______**FRFP to Request Records**

Patient's Name: ________________________________ **Requested Date**: ____________________________

Date of Birth: __________________________________ **Medical Record Number**: ______________________

1. I authorize the use and/or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to disclose and to receive my health information:

Doctors Name: ____

Address: ____

City, State and Zip Code: ____

Phone Number: ____________________________ **Fax**: ______________________________

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

_______ Problem List/Core Data Sheet
_______ Medication List
_______ List of Allergies
_______ Immunization Record
_______ Most Recent History and Physical
_______ Most Recent Progress Note
_______ Consultation Reports

Other Physician/Hospital Records from:
_______ Laboratory Results Dated: ________________ to ________________
_______ X-Ray/Imaging Reports Dated ________________ to________________
_______ Other ____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about Behavioral or Mental Health services, and treatment for alcohol and drug abuse.

5. The information may be disclosed to or from the following individual or organization:

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630
Phone: 540-631-3700
Fax: 540-635-1673

For the purpose of: Continuity of Care/Coordination of Services

Are you transferring care? __________ If yes, Why: ____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 (one) year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

If I have questions about the disclosure of my health information, I can contact the practice privacy office.

Signature of Patient or Guardian: ____

Relationship to Patient ____ Date: __________________________