P.L. Physicians, Inc. – 4550 Empire Court – Fredericksburg, VA 22408
Ph #: 540-361-1800

AUTHORIZATION FOR RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Name of Authorized Representative: _____ Phone Number: (_____)_____

I, _____ as an authorized personal representative, authorize P.L. Physicians, Inc. to release the healthcare information (medical records) of the of above-named patient to:

*Person Receiving Records:

_____

Contact Phone Number:

(_____)_____

**Once the requested medical records have been copied/prepared, you will be contacted at the phone number provided advising that it is available for pick up at the P.L. Physicians clinic.*

OR

(Transfer) Name of Provider or Practice Receiving Records:

_____

Address:

_____

City, State, Zip Code:

_____

Phone# / Fax#:

_____/_____

FORMAT OF MEDICAL RECORDS (Select One): ☐ Electronic (CD) ☐ Paper

INFORMATION TO BE RELEASED: Entire Medical Record

PURPOSE FOR THIS RELEASE: Medical Practice Closure

I UNDERSTAND THAT:

- Authorizing the disclosure of this patient health information is voluntary and that I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance of my prior authorization.
- There is an administrative fee of **$10.00** for the production of medical record copies.

Signature of Patient or Authorized Representative: _____ Date: _____

Relationship to Patient: _____

For Office Only / Auth Received:	Filled:	Contacted:	Picked-Up: