RG LAW, PLLC
9990 Fairfax Blvd
Suite 540
Fairfax, Virginia 22030
(703) 352-8833; (703) 352-8881 (fax)

PATIENT AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS (PROTECTED HEALTH INFORMATION)

DATE: ______________________

TO: ____

I hereby authorize you to release and/or discuss my medical records and protected health information to my attorney, his firm, and staff at the following:

RG LAW, PLLC
9990 Fairfax Blvd
Suite 540
Fairfax, Virginia 22030
(703) 352-8833; (703) 352-8881 (fax)

Purpose of Release and/or Disclosure:

[x] At the request of the patient

Records/Information to be Released:

[ ] ALL records
[ ] Chart notes for office visits from date of____________________
[ ] All billing statements and/or charges
[ ] Operative /pathology report(s) from date of _______________
[ ] Lab results from date of ______________
[ ] Radiology films and/or reports from date of ________________
[ ] Other ____

- I understand that I may revoke/cancel this authorization at any time by giving written notice of my decision to do so;
- I understand that once my records are released that they will no longer be within your control and could potentially be re-released or re-disclosed by the recipient;
- This release is made at my request and I understand that my treatment is not dependent on whether I choose to sign this form;
- I understand there may be a cost for photocopying, handling, & mailing of my records;
- This authorization will expire on ________________.

____
NAME PRINTED / If Personal Representative, note relationship to patient SIGNATURE

____
PATIENT ADDRESS

____
CITY, STATE, ZIP PHONE

____
SOCIAL SECURITY NO. DATE OF BIRTH