AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Patient name), authorize

_____
(Organization Name)

_____
(Address) (City) (State) (Zip Code)

_____
(Phone Number) (Fax Number)

To ☐ RELEASE TO ☐ OBTAIN FROM

County Med, LLC

103 E. Broad St., Blackstone VA 23824

(434)264-3221 (Office) (833)464-4570 (Fax)

The following information:

☐ Discharge Summary
☐ Laboratory Reports:
_____
☐ Diagnostic Reports
☐ History and Physical
☐ Progress Reports

☐ Treatment Plan
☐ Immunization Records
☐ Medication Records
☐ Current ☐ All
☐ Entire Medical Record

for the purpose of:

☐ Evaluation and Treatment
☐ Coordinate Services

☐ Transfer Care
☑ Other:
_____

I understand that my health information is protected unless required to be released by law. I authorize the release of my health information. I understand that I can cancel this consent with written notice at any time but that it will not apply to information already released. I understand that County Med, LLC can not be held accountable for the handling of information once it is released.

Unless revoked, this consent will expire one year from the date signed.

Patient Name (printed): _____

DOB: _____ Today's Date: _____

Patient/Parent/Guardian Signature: _____

Relationship (if signed by someone other than the patient): _____

Witness Signature: _____ Today's Date: _____