Release of Medical Information

Fox and Brantley Internal Medicine
908 E. Jefferson St., Suite G1
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Phone: 434-244-5684 Fax: 434-244-5685

Authorization for Release of Information: **_____20_____**

I _____authorize_____to release the
(Name) (Facility/Hospital/Physician)

Information checked below to _____at the above address.
(Physician)

☐ Entire Record	☐ History & Physical Exams	☐ Laboratory Report	☐ Operative Report
☐ Pathology Report	☐ ER Report	☐ Consultation Report	☐ Other _____
☐ Discharge Summary	☐ Billing and Payment History	☐ Radiology Report	_____

Dates of Service: _____
Patient Name: _____
Date of Birth: _____ Social Security Number (optional):_____
Phone Number: H: (____) _____ W: (____) _____

Purpose of request: ☐ Personal Use ☐ Continuing Care ☐ Other_____

As the person signing this authorization, I understand that I am giving my permission to disclose confidential health care records including, if applicable, PSYCHIATRIC, DRUG/ALCHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law.
I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on my signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

Special Instructions:_____

Signature of Patient or Legal Representative: _____ **Date**: _____

If signed by legal representative, indicate relationship to patient:_____

This authorization is only valid for the information/purpose(s) indicated above, and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.