PL Physicians, Inc.

4550 Empire Court
Fredericksburg, VA 22408
Ph#: 540-604-9894
Fax#: 540-604-9895

Authorization for Release of Medical Information

Patient's name:_____ Date of Birth:_____

Address:_____

City/State/Zip Code:_____

SSN:_____ Patient's phone #: ( )_____

Date of Request:_____ Date Needed:_____

☐ I authorize PL Physicians, Inc. to release information to:	☐ I authorize PL Physicians, Inc. to obtain information from:
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)	_____ Phone #/Fax # (include area code)

INFORMATION TO BE RELEASED:

__Office visits __X-ray Reports __Immunization Record
__Disability Information __Medication List __Entire Medical Record
__EKG __Lab Results

PURPOSE FOR THIS RELEASE:

__Continuity of Medical Care __Location
__Insurance __Not satisfied with Medical Care

I UNDERSTAND THAT:

- **Any records from prior doctors or specialists will have to be requested by myself**.
- My right to healthcare treatment is not conditioned on this authorization.
- This authorization will remain valid for the duration of my care at PL Physicians, Inc.
- 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 on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There **may** be a charge for the requested records. (Virginia Law allows for copy charges consisting of the following: $10 administration fee **PLUS** $0.50 per page for the first 50 pages and $0.25 per page thereafter.)

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative:_____ Date:_____

Relationship to Patient (*if requester is not the patient)*_____