AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth: _____ SSN: _____

Address (street, city, state, zip) _____

_____ Telephone #: _____

FROM: *The following individual or organization is authorized to make the disclosure*

PRACTICE NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

TO: *This information may be disclosed to or used by the following individual or organization:*

FAMILY MEDICINE OF ALBEMARLE, 1450 Sachem PL, Suite 201, Charlottesville, VA 22901

Telephone: (434) 973-9744 Fax: (434) 973-9790

Treatment Dates: _____

Purpose of Request: _____

(unless your medical history dictates otherwise, please limit amount forwarded to less than 3 years)

The following information is to be disclosed: ***(one box must be checked for each item)***

Physician Notes	□**Yes** □ **No**	Lab Results	□**Yes** □ **No**	Xray Reports	□**Yes** □ **No**
MRI Scans	□**Yes** □ **No**	Cardiac Studies	□**Yes** □ **No**	Complete Record	□**Yes** □ **No**
Other (please specify) _____					□**Yes** □ **No**

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. **I authorize the release of this information.** □**Yes** □ **No**

RE-DISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. However, if this authorization is needed to participate in a research study, my enrollment in the research study may be denied.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(if I do not specify an expiration date, event, or condition, this authorization will expire automatically in six months.)* _____

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____ _____

DATE

If signed by legal representative, relationship to patient: _____