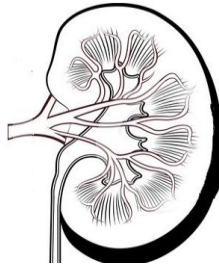


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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date of Request _____ Reason for Release _____

Patient Name _____ Date of Birth _____ Phone Number _____

Address _____

This authorizes _____ to provide a copy, summary, or narrative of my medical Records as indicated by the checkmark(s) below, or otherwise release confidential information.

Please list what medical information you would like to be released.

☐ All records (dates) _____ ☐ X-Rays ☐ Labs
☐ Office Notes ☐ Hospital Records ☐ Other _____

Please release my medical records to:

Facility Name or Person _____

Address _____ City _____ State _____ Zip _____

This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand once the information below is released it may be re-disclosed by the person or facility receiving it, and would then no longer be protected by federal privacy laws and regulations. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that in accordance with 8.01-413 of the Code of Virginia there is a flat fee of \$6.50 for each request. Fees are waived when copies are requested by other health care provider's agencies/facilities for continuing care. All other requestors are charged as state and federal laws allow.

Signature of Patient or Legal Guardian _____

Signature of Witness _____

Date _____

Date _____