



**LOUDOUN
INTERNAL MEDICINE
ASSOCIATES**

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Authorization for Release of Medical Information

Print Patients Full Name

Date of Birth

Street Address

Social Security Number

City/State/Zip Code

Home Phone Number

Discharge Summary
 History & Physical
 Progress Notes

Pathology Reports
 Laboratory Reports
 Radiology Reports

Emergency Reports
 Other

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM:

PLEASE RELEASE INFORMATION TO:

PURPOSE OF DISCLOSURE:

Referral to Specialist Insurance Workers Comp Change of Doctor/Provider
 Legal Investigation Personal Continuing Care Disability Determination
 Other (please specify) _____

Note: There may be a charge for a personal copy or the permanent transfer of your records as follows: A \$10.00 base fee, \$0.50 per page for pages 1-50, then \$0.25 for any pages over 50.

Please provide the best telephone number in the event we need to contact you (home, work or cell)

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I hereby authorize disclosure of the health information for the above named patient. 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 that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual, Guardian or Legal Representative

Date