

MANASSAS INTERNAL MEDICINE

9303 Forest Point Circle ■ Manassas, VA 20110-4700
Office (703) 257-7749 ■ Fax (703) 257-1967

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO MY PRIMARY PHYSICIAN

ALL SECTIONS MUST BE COMPLETED

Request health

Information from: *Name/Title/Organization* _____

Address _____

Phone () _____ Fax () _____

Please Print: Patient Name _____ Date of Birth _____

Address _____

Phone () _____ Date[s] of Service _____

I authorize *the entity stated above* to release the above named individual's health information as described below:

1. The type and amount of information to be used or disclosed is as follows:

<input type="checkbox"/> History and Physical*	<input type="checkbox"/> Consultation Report*	<input type="checkbox"/> Complete Chart*
<input type="checkbox"/> Operative Note*	<input type="checkbox"/> Laboratory Results*	<input type="checkbox"/> HIV Records**
<input type="checkbox"/> Pathology Report*	<input type="checkbox"/> Nurses' Notes*	<input type="checkbox"/> Other _____
<input type="checkbox"/> Radiology/Imaging Report*	<input type="checkbox"/> Progress Notes*	_____
<input type="checkbox"/> EKG Report*	<input type="checkbox"/> Physicians' Orders*	

* I understand that minimum necessary guidelines of HIPAA may apply.

** I have marked the applicable boxes if I am requesting HIV records to be released. These records will not be released with the "Complete Chart" unless specifically requested.

2. This information may be disclosed to and used by the following organization:

Manassas Internal Medicine
9303 Forest Point Circle
Manassas, VA 20110-4700

Office (703) 257-7749

Fax (703) 257-1967

3. For the purpose of: At the request of the individual Other _____

4. I understand that the information may be redisclosed by the person or entity identified above and will no longer be protected by federal privacy regulations. I further understand that I may revoke this consent to release information at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization.

5. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

_____ SIGNATURE	_____ DATE	
_____ IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	_____ SIGNATURE OF WITNESS	_____ DATE