MANASSAS INTERNAL MEDICINE

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

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL SECTIONS MUST BE COMPLETED

Patient Name ______________________________ Date of Birth ______________

Address ______________________________ Patient Number

Phone ( ) ______________ Date of Service ______________

I authorize Manassas Internal Medicine 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:

☐ History and Physical*	☐ Consultation Report*	☐ **Complete Chart***
☐ Operative Note*	☐ Laboratory Results*	☐ **HIV Records****
☐ Pathology Report*	☐ Nurses' Notes*	
☐ Radiology/Imaging Report*	☐ Progress Notes*	☐ Other ______________
☐ EKG Report*	☐ Physicians' Orders*	______________

* Manassas Internal Medicine adheres to minimum necessary guidelines of HIPAA.

** You must mark the applicable boxes if you are 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 individual or organization:

   Name/Title/Organization: ______________________________

   Address: ______________________________

   Phone ( ) ______________ Fax ( ) ______________

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

Young k. Kim, DO John F. Cary, MD Kajal V. Parikh, MD Kimberley Ryan, FNP
Ladonna Wagner FNP

MANASSAS INTERNAL MEDICINE, PC
9303 FOREST POINT CIRCLE
MANASSAS, VA 20110
TAX ID # 541666596

Date requested: ______________________

Patients (you) are entitled to copies of their medical records and we will provide them upon written request by the patient or authorized representative.
Also, medical practices (we) are entitled to be paid for providing the copies.
When you request copies of your medical records please follow these steps.

1. **AUTHORIZATION FORM:** In certain cases the law requires patient to authorize copying in writing. You may obtain the release form from our office. By law you may not request copies of the records of another adult, even a family member, unless you have a proper authorization. We accept faxed authorization forms at 703 257 1967.

2. **COST:** Virginia State laws define the fees that may be charged to you. You pay these costs in advance directly to Manassas Internal Medicine

You can speed up the process by prepaying your fees with a credit card when you call our office at 703 257 7749.

FEES ARE: As defined by Virginia State Code Section 8.01-413 (2003) there is a $10.00 administrative fee to have your medical records release to you. In addition, there is a $0.50 per page fee for the first 50 pages. For more than 50 pages each page thereafter, is a $ 0.25 charge.

3. **RESPONSE TIMES:** Virginia law provides two weeks to respond to copying request. Most requests will be fulfilled in less time, once the fees are paid. Please do not expect the copying to be done while you wait, unless it is a medical emergency.

The fée for medical records request for patient________________ DOB___/___/____

Processing fee $ 10.00
________Pages at 0.50 per page $ ______
________Pages at 0.25 per page $ ______
Postage $ ______

Total Amount for the records $ ___________

- RECORDS ON CD FLAT FEE $ 15.00

If you wish to cancel your authorization for us to send your medical records please let us know in writing. Otherwise, the authorization to release your records will expire three months from the date of your request.

Thank you.

ANGELA SHAMEL
Practice Manager