MANASSAS INTERNAL MEDICINE

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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