GENERAL INTERNAL MEDICINE GROUP, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patients full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Social security number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize General Internal Medicine Group to:

☐ **Obtain records from**: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

☐ **Release records to**: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

Service Dates _____

_____ LAST TWO YEARS	_____ PATHOLOGY REPORTS	_____ ENTIRE CHART
_____ OFFICE NOTES	_____ LABORATORY REPORTS	_____ SPECIFIC TEST _____
_____ PROCEDURE NOTES	_____ RADIOLOGY REPORTS	_____ OTHER_____

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

☐ Paper Copy ☐ Electronic Copy

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST	_____ INSURANCE	____WORKERS COMP	_____ LEAVING PRACTICE
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	____ PERSONAL	_____ RELOCATION / MOVING

OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

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 effect 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.

NOTE: <u>Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia Rates are pgs 1-50 at $0.50 per pg, pgs 51+ at $0.25 per pg plus postage & handling. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS</u>.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate Power of Attorney Must be Attached **Date**

<u>MEDICAL INFORMATION RELEASED BY HEALTHPORT</u>

ENTIRE ___ LAB ___ EKG ___ PATH ___ _____
DS _____ IMMUNE ___ H&P ___ ROI SPECIALIST DATE
OP _____ X-RAY _____ OTHER _____ _____