Authorization To Release Confidential Medical Information

Name_____ DOB ___/___/___ SSN ___-___-___
Address _____
_____ Phone (___)_____

( ) I authorize **Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg, 1708 Fall Hill Avenue, Fredericksburg, Va. 22401**, (540) 371-1226, to release the information specified below, in accordance with the laws of Commonwealth of Virginia, and Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg policies, to the party identified below.

( ) I authorize the party identified below to release the specified information to **Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg, 1708 Fall Hill Avenue, Fredericksburg, Va. 22401**, (540) 371-1226.

Receiving/Obtaining Person or Organization:
Name _____ Organization _____
Street Address _____
_____

Information To be Released/Obtained

Physician's Progress Notes	_____	Radiology Report	_____
Final Discharge Summary	_____	Consultation	_____
Emergency Room reports	_____	Audiological tests	_____
History and Physical	_____	Lab Report	_____
Operative Report	_____	Complete Chart *	_____

Other (Please Specify) _____

Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.

Dates of Service _____ to _____ Medical Record # _____

The purpose for the disclosure of the above information is:
_____ Continuing care
_____ Personal use
_____ Other (Please specify)_____

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter.

I hereby authorize, allow and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Ear, Nose & Throat and Facial Plastic Surgery Center of Fredericksburg from, and covenant not to sue ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg for any claim I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, even or condition described as: _____.

Patient Signature _____ Date ___/___/___

Parent/Guardian/Patient Designee Signature _____ Date ___/___/___

Authority of Individual Signing for Patient _____

Witness Signature _____ Date ___/___/___