AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS

Virginia Medical Alliance, P.C. 5510 Alma Ln. #100 Springfield, VA 22151
Phone # 703-813-1219 Fax # 703-642-5410

Patient's Name: _____ Daytime Telephone #_____

Address: _____

Date of Birth: _____ Social Security #: _____

AUTHORIZATION

I hereby authorize the use or disclosure of my individual health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, and eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE OF LIABILITY

I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by Federal privacy regulations. Therefore, I release Virginia Medical Alliance, P.C. from any and all legal liability that may arise from the release of this information to the party named below. **Please initial:** _____.

ORGANIZATION PROVIDING INFORMATION

_____
Name of person/organization releasing information

_____
Street Address, City, State, Zip

Phone #: _____ **Fax #:** _____

ORGANIZATION RECEIVING INFORMATION

_____
Name of person/organization receiving information

_____
Street Address, City, State, Zip

Phone #: _____ **Fax#:** _____

INFORMATION TO BE DISCLOSED

_____ **Complete Health Records** _____ **X-Ray Reports**

_____ **Consultation Reports** _____ **Laboratory Reports**

_____ **Pre-Operative Reports** _____ **Other Reports**

PURPOSE OF DISCLOSURE

_____ **Second Opinion** _____**Continuing Medical Treatment**_____**Patient Request** _____**Other**

BY SIGNING THIS AGREEMENT BELOW, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient, Guardian, or Legal Representative: _____**Date:** _____