Authorization for the Release of Medical Records

PATIENT INFORMATION

Name: DOB: SSN: XXX-XX-

Address:

City: State: Zip:

Phone#: Fax#:

OBTAIN RECORDS FROM

Name:

Address:

City: State: Zip:

Phone#: Fax#:

RECORDS TO BE RELEASED

o All Records o Office/Clinic Notes o Operative Reports

o Lab/Pathology Results o Radiology Reports o Immunization Records

o Dates_____ to _____

o Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

o Substance Abuse, if any o AIDS/HIV/STDs, if any o Psychological/Psychiatric conditions, if any

PATIENT SIGNATURE

I hereby authorize PrimeCare and its affiliates to obtain medical records from the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. 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 affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to Patient:

Send to: PrimeCare, 2511 Salem Church Road, Fredericksburg, VA 22407 • P: 540-786-1200 F: 540-786-3195

****PLEASE BE COURTEOUS AND DO NOT FAX MORE THAN 20 PAGES****