AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION
PATIENT INFORMATION

Patient Name: ____ Acct. No#. ___________
Former Name (if any): ______________________________________ SS. No#. ___________
Daytime Telephone: ____ Birth Date: ____/___/_______

INFORMATION TO BE RELEASED FROM:

I hereby authorize Family Psychiatric Associates (FPA) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from FPA, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from FPA. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Name of Organization Street Address City/State/Zip

____

Purpose or need for this information is: ____

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

Type of Record

_________ Medical Records/Excluding Protected Records
(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).

_________Lab Results (specify) ____
_________X-ray Reports (specify) ____
_________Surgical records (specify) ____
_________Other records (specify) ____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

_________Drug Abuse Diagnosis/Treatment (specify) ______________________________
_________ Alcoholism Diagnosis/Treatment (specify) ______________________________
_________Mental Health Diagnosis/Treatment (specify)_____________________________
_________Sexually Transmitted Disease (specify)__________________________________
Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify)____________________

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior to notifying Family Psychiatric Associates in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed for copies of my medical record according to HIPAA State of Virginia and Federal law.

_______________________**X**____

Date Signature of Patient/Relationship to
Legally Responsible Party Patient if not Patient

FPA Use only: Total Fee:________Internal Processing:___________ External Processing: __________
Date Received Request:_________ Date Mailed/Faxed/Patient picked up from Office:_____________