Authorization to Release Medical Information

Greenbrier Family Practice PC, PO Box 13782, Chesapeake, VA 23325
Voicemail: (757) 547-0999

Please Print Clearly

Patient Full Name: ________________________________ Date of Birth: ____________________

Patient Telephone Number: ____

Patient Address: Name, Street Address, City, State, Zip

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I hereby request and authorize release of my medical records as described below to:

Name, Street Address, City, State, Zip

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Telephone: _____________________________ Fax: __________________________________

For the purpose of continuing care,
I hereby authorize the use or disclosure of my protected health information as described below. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law, information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I acknowledge that the information to be released may include sensitive information such as HIV or STD tests, substance abuse and counseling information, unless I indicate otherwise.

I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be effected if I do not sign this form, unless that treatment is for fitness-for-duty evaluation or a research-related treatment. I understand and agree to pay the costs for my records are $15.00 for administrative processing fee, plus 20 cents per page fee, plus postage cost.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

This authorization is valid for 12 months from the date of signature. I understand that I have a right to revoke this authorization by sending written notification to the Facility Privacy Officer at the above address. Any revocation will not affect disclosures made prior to Greenbrier Family Practice's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.
Patient or patient representative's

Signature: ________________________________ Date: ______________

INFORMATION TO BE RELEASED:

- ☐ Summary of medical record with pertinent lab and xray reports (The most recent and important records)
- ☐ Operative Reports ☐ Emergency Room Records ☐ X-Ray Reports
- ☐ Pathology Reports ☐ Lab Reports ☐ Mammography Reports
- ☐ Historical records from other practices which may be on file
- ☐ Entire GFP PC Record ☐ Other ____

(Form Rev 9-1-2019)