

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

<b>PATIENT NAME</b>		<b>DOB</b>	
<b>PHONE #</b>		<b>LAST 4 SSN:</b>	XXX - XX -

I request and authorize the following entity:

<b>NAME</b>			
<b>ADDRESS</b>			
<b>PHONE #</b>		<b>FAX #</b>	

to release health care information of the patient named above to:

<b>NAME</b>			
<b>ADDRESS</b>			
<b>CITY</b>		<b>STATE</b>	<b>ZIP</b>
<b>PHONE #</b>		<b>FAX #</b>	

**This request and authorization applies to:**

- Healthcare information relating to the following treatment, condition or dates: \_\_\_\_\_
- All healthcare information
- Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
- Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

**Purpose of disclosure:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Specialist Referral | <input type="checkbox"/> Continuing Care   | <input type="checkbox"/> Updating Personal Records |
| <input type="checkbox"/> Insurance Request   | <input type="checkbox"/> Change of Doctors | <input type="checkbox"/> Other: _____              |

I realize that by signing this form that I am authorizing the release of my medical information. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it. I understand I may cancel this request at any time with a written notification. I understand there may be a charge for record copying services and I am responsible for paying these fees. The standard copying fee is \$0.50 per page for the first 50 pages, and \$0.25 per page thereafter.

<b>SIGNATURE</b>	<b>DATE</b>

This authorization is valid for 12 months from the date signed

Please note that according to Virginia State law, we are only required to maintain patient medical records for six years from the last patient encounter with the following exceptions: 1) Records of a minor child, including immunizations, must be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child; 2) Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or 3) Records that are required by contractual obligation or federal law to be maintained for a longer period of time.