

# Release of Medical Information

Fox and Brantley Internal Medicine

916 E. High St. Suite 1

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Phone: 434-244-5684 Fax: 434-244-5685

Authorization for Released of Information: \_\_\_\_\_ 20\_\_\_\_\_

I \_\_\_\_\_ authorize \_\_\_\_\_ to release the information  
(Name) (Facilty/Hospital/Physician)

checked below to \_\_\_\_\_ at the above address.  
(Physician)

Discharge Summary	History of Physical Exam	Laboratory Report	Operative Report
Pathology Report	ER Report	Consultation Report	Other _____
Entire Record	Billing and Payment History	Radiology Report	_____

Dates of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number (optional): \_\_\_\_\_

Phone Number: H: (\_\_\_\_) \_\_\_\_\_ W: (\_\_\_\_) \_\_\_\_\_

Purpose of request: Personal Use Continuing Care Other \_\_\_\_\_

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include if applicable, PSYCHIATRIC, DRUG/ALCHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I

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lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on my signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

Special Instructions: \_\_\_\_\_

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by legal representative, indicate relationship to patient: \_\_\_\_\_

This authorization is only valid for the information/purpose(s) indicated above, and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.

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