PRIVIA MEDICAL GROUP
Authorization For Release of Medical Information

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

At the request of the individual, I _____, do hereby authorize _____ to release:
(Patient's Name) (Name of Facility)

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Address

Phone Number **Fax Number**

City, State Zip Code

The specific information that should be disclosed is (include dates of service):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

I hereby authorize disclosure of the health information for the above named patient. 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 of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
OR, if applicable –		
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility may contract with a business associate to provide this service and they will invoice you directly. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

Official Use Only		
Received	**Processed By**	**Log #**