Orange Family Physicians
AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

I _____ authorize Orange Family Physicians to release the information checked
(name)

below to _____ at the following address:
(Name of Recipient(s))

_____

☐ Office Notes ☐ History and Physical Exam ☐ Laboratory Report

☐ X-Ray/EKG Report ☐ Entire Record ☐ Billing & Payment History

☐ Other _____

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/ALCOHOL 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. 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 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 law does not permit revocation.

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.

Virginia Law allows for copy charges consisting of the following: $10.00 administration fee PLUS $ .50 per page for the first 50 pages and $ .25 per page for thereafter.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me 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: _____ (none if blank)

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal representative, indicate relationship to patient.

☐ Identification verified

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.