ORANGE FAMILY PHYSICIANS
A Division of Anchor Healthcare, PLC
13198 James Madison Hwy.
Orange, Virginia 22960
Telephone: 540 672-3010 Facsimile 540 672-5713

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you to release the checked information to Orange Family Physicians at the above address.

Name of Physician or Facility: _____

Address of Physician or Facility: _____

_____

☐ Last Year of Office Notes ☐ Last History & Physical Exam ☐ Last Year of Laboratory Reports

☐ Last EKG/Chest X-ray Report ☐ Last Hospital History & Physical ☐ Last Hospital Discharge

☐ Other _____

Patient Name: _____ **Date of Birth:**_____

Social Security Number (optional):_____

Phone Number Home: _____**Work:** _____

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.

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