Albemarle Center for Family Medicine

A division of Anchor Healthcare, PLC
535 Westfield Rd. Suite 200, Charlottesville, VA 22901
Ph. (434) 973-4040, Fax (434) 974-1780

AUTHORIZATION FOR RELEASE OF INFORMATION

_________________**20**______

I________________________________ authorize Albemarle Center for Family Medicine to release the information checked
(Name)

below to____ at the following address: ________________________________
(Name of recipient(s))

____

I would like this information:

Mailed to the address provided above   Faxed to_____________________   Picked up by__________________

Please indicate which sections of the chart you would like to be released:

☐Last Year of Office Notes ☐Last History and Physical Exam ☐Last Year of Laboratory Reports
☐Last EKG ☐Immunization Record ☐Last ED Report
☐Radiology Report(s) ☐Last Hospital Admission and Discharge Summary
☐Consultation Report(s) ☐Entire Record from _______ to __________

☐Billing & Payment History from_________ to________

Patient Name: ____

Date of Birth: __________________ **Medical Record Number:** ______________________

Phone Number **Primary: (_____)_______________________ Secondary: (______)___________________________**

Purpose of request: ☐Personal use ☐Continuing Care ☐Transfer of 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 revocation is not permitted by law.

I agree that I am financially responsible for the fees associated with my request: $.50 per page up to 50 pages, $.25 per page 51 pages and up, a $10 search and handling fee plus all postage and shipping costs. Fees may be waived for your first copy or when sent directly to other health care providers or agencies.

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.

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.