LOUDOUN MEDICAL GROUP
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____/_____/_____
Print patient full name Birth date

_____ _____-_____-_____
Street address Social Security Number

_____ (_____) _____
City/State/Zip Home phone number

At the request of the individual, I _____, do hereby authorize _____ to release:

_____Discharge Summary	_____Pathology Reports	_____Emergency Reports	
_____History & Physical	_____Laboratory Reports	_____Other	_____
_____Progress Notes	_____Radiology Reports		_____
_____Operative Notes	_____ECG/EEG/Cardiac Cath		_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agent/Facility/Person

_____
Street Address

_____
City/State Zip

PURPOSE OF DISCLOSURE

_____Referral to specialist	_____Insurance	_____Workers Comp	_____Change of Doctor/Provider
_____Legal investigation	_____Disability determination	_____Personal	_____Continuing care

_____Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home or work or cell): (_____)_____-_____

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.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate Date

NOTE: There may be a charge for a personal copy of the permanent transfer of your records as follows: a $10 base fee, $.50 per page for page 1-50, $.25 for any pages over 50.