Greater Prince William Community Health Center

Your Home for a Healthy Family and a Healthy Community

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Medical Release of Information Authorization

***Fill out form in its entirety.*

Patient Name: _____ Date of Birth: _____

Medical Record No. (if known) _____

I authorize the use/disclosure of health information about the above-named patient as described below:

The information is to be released from:	**The information is to be provided to:**
☐ Greater Prince William Community Health Center ☐ Organization/Individual:	☐ Greater Prince William Community Health Center ☐ Organization/Individual:
Address	
City/State	
Fax#	

Date of Service/s: From:_____ To:_____

Check the specific confidential information:

____Office Visit Notes ____Lab Reports ____OB/GYN ____EKG/Cardiology Reports ____Radiology Reports
____Immunization Records ____History & Physical ____Pathology Reports ____Radiology Images
____Referral Consultation Notes ____Billing Statements
__ Other: _____

I authorize the information listed below to be used, disclosed and/or received:
____Developmental disabilities information ____AIDS, HIV, ARC

The purpose or need for this disclosure is:
□Further Medical Care □Attorney □School □ Personal Use /Request of Individual
□Insurance/Benefits □Disability Determination
□Other (*Specify*) _____

The information may be transmitted via (consumer ***must*** initial each approved communication method)
_____ fax _____ verbal _____electronically (***required*** to complete duty to warn) _____hard copy

- I understand that if the person or entity that receives the health information is not a health care provider or health plan covered by federal privacy regulations, the health information above may be subject to redisclosure and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by notifying the Privacy Official except to the extent that action has been taking in reliance on this authorization.
- **Unless revoked, this authorization will expire 6 months from the date signed or as specified: _____**
- I may inspect or copy any information used/disclosed under this authorization. I have received a copy of this authorization.

I further acknowledge that the information to be released has been explained to me and certify that this consent is given on my own free will.

_____ _____
Signature of Patient or Legally Designated or Personal Representative Date

_____
Please print name of Legally Designated or Personal Representative (if applicable)