HealthVisionsMD, Inc.
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Authorization to Release Medical Information

______________________________ ____/____/____ ______________
Patient Name | DOB | Last 4-digits SSN

______________________________ ______________ ____ ______
Address | City | ST | Zip

I, hereby authorize: ____
(Name of Organization to Disclose Information)

To Disclose the Following Information for the Date(s) of Service: ______________________

☐ **Entire Medical Record**
☐ Laboratory Report ☐ Immunization Only ☐ Last Two Years
☐ Radiology Report ☐ Pathology Report ☐ Office Notes

☐ I do ☐ I do not
Give my permission to disclose confidential health care records relating to, if applicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), psychiatric and/or psychological assessments, which may include behavioral or mental health services and treatment for alcohol and drug abuse.

Disclosure Format (Paper format is default, if not indicated below)

☐ US Mail
☐ Electronic Format: CD/DVD ☐ eDelivery
☐ Radiology Film/CD Email: ______________________

Information Released to: ____

Purpose of Disclosure:

☐ **Leaving Practice**
☐ Disability Determination ☐ Insurance ☐ Personal
☐ Worker's Compensation ☐ Legal ☐ Other ______________

Authorization to Release Information:

I understand that:

1. I do not need to sign this authorization form to receive health care benefits (treatment, payment, or enrollment).
2. I hereby authorized the release and disclosure of the health information for the above name patient.
3. This authorization will expire **12** months from the date of signature, unless otherwise revoked.
4. I have the right to revoke this authorization, at any time, with written notification to the HealthVisionsMD; and, the revocation will not apply to information that has already been released in response to this authorization. *Additional details may be found in the Notice of Privacy Practices.*
5. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
6. I may inspect or copy the information to be used or disclosed.
7. I will be given a copy of this authorization form, after signing.
8. Copying charges will be applied. **NOTE:** **Virginia Law permits a charge for personal copy or transfer of your records. The current Virginia rates are $0.50 per page (Pages 1-50) and $0.25 per page (Pages 51+) plus postage & handling.**

______________________________ ______________ ______________
Patient / Authorized Representative* Signature | Telephone | Date

By signing this form as "Authorized Representative" on behalf of the minor, incapacitated or otherwise legally dependent patient, you represent to HealthVisionsMD that you have legal authority to act on behalf of the patient. ☐ **Power of Attorney must be attached.**

HealthVisionsMD Use Only

Processed by: ______________________ ☐ Identify Verified ☐ Signature Verified