Paramount Care Physicians

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ (Print patient's full name)

_____ (Birth Date) Month/Date/Year

_____ (Street Address)

_____ (Social Security Number)

_____ (City, State, Zip Code)

_____ (Home Phone)

I _____ do hereby authorize Paramount Care Physicians to release my medical records:

_____ Labs
_____ X-ray
____ EKG
____ Mammography
_____ Office Notes
_____ Pathology Report

Other (Specify): _____

___ I DO or ___ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) Infection, Psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

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

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

__ LEGAL INVESTIGATION
__ LEAVING PRACTICE
__ PERSONAL
__ DISABILITY DETERMINATION
__ INSURANCE
__ CONTINUING CARE

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. Section 32.1-127.1:03 of the Virginia Board of Medicine Guidance Document state that medical records are the property of the health care provider. Section 54.1-11 allows a practitioner to charge a reasonable fee, not in excess of the amount authorized in Code of Virginia Section 8.01-413. Such charges shall not exceed $15.00 for reproduction to CD of all records in our possession, a fee for search and handling, not to exceed $10, and all postage and shipping costs. I understand that I may cancel this request with written notification but that it will not affect any information already released and/or any fees related to the request. 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 health care provider has fifteen days from receiving the request to either furnish the records or inform the requester that the records cannot be found or do not exist.

_____ Signature of patient or guardian

_____ Date

Revised 05/01/2014