James River Internists
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print patients full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) social security number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, hereby authorize

INFORMATION RELEASE FROM: _____
NAME (Physician, hospital, agency, etc.)

Phone# _____ _____
Street address

Fax# _____ _____
City, state, zip

_____PROGRESS NOTES	_____PATHOLOGY REPORTS	_____ ALL RECORDS
_____OTHER DOCTORS NOTES	_____LABORATORY REPORTS	_____IMMUNIZATIONS
_____OB/GYN NOTES	_____RADIOLOGY REPORTS	_____OTHER _____
_____HOSPITAL NOTES	_____ECG/EEG/CARDIC 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: **James River Internists**
13440 Tredegar Lake Pkwy
Midlothian, VA 23112
Phone # (804) 745-2200 Fax # (804) 745-9224

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL

OTHER (SPECIFY)_____

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 effect 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 is authorized 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**

Reason for transferring: _____

NOTE: <u>THERE WILL BE A CHARGE FOR RECORDS IN ACCORDANCE WITH THE VA CODE 8.01-413 $.50 (PER PAGE UP TO 50 PG) ADDITIONAL $.25 PER PAGE (FROM PAGE 51 & UP) + ACTUAL POSTAGE. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.</u>

MEDICAL INFORMATION RELEASED BY HEALTHPORT

Entire_____ LAB_____ mammogram_____ _____

IMM_____ EKG_____ number of pages_____ HEALTHPORT ROI SPECIALIST

PN _____ X-ray_____ other_____ _____

PL/MEDS_____ Path_____ _____ DATE