truong REHABILITATION CENTER

Rehabilitation Medicine Physicians
Pogonia Medical Arts Building, 4604 Spotsylvania Parkway, Suite 303
Fredericksburg, VA 22408
(540) 374-3164 Fax (540) 899-1342

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Name: _____ DOB: _____/_____/_____ SSN: _____
Address_____ City: _____ State: _____ Zip: _____
Phone: (___) _____-_____

( ) authorize Rehabilitation Medicine Physicians to release the information specified below, in accordance with the laws of Commonwealth of Virginia, to the party identified below or
( ) authorize the party below to release the specified information to Rehabilitation Medicine Physicians

_____ Release of Information to Persons/Organization as noted below
_____ Release of Information by Persons/Organization as noted below
Name: _____
Organization: _____
Street Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Information to Be Released/Obtained

_____ Physician Progress Note _____ Radiology Reports
_____ Final Discharge Summary _____ Consultation
_____ Emergency Room Reports _____ Complete Chart*
_____ History and Physical _____ Psychiatric Records
_____ Laboratory Results _____ Drug and Alcohol
_____ Operative Reports _____ HIV Records
_____ Other
* Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.

Dates of Service: _____/_____/_____ to _____/_____/_____ Medical Record #: _____

The purpose of the disclosure of the above information is:
_____ Continuing Care _____ Personal Use _____ Other: _____

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter. I hereby authorize, allow, and consent to the release of information indicated above. No threat of utter (?? or other?)coercive measure has induced me to sign this form and I do release Rehabilitation Medicine Physicians from and covenant not to sue Rehabilitation Medicine Physicians for any claim I have or may in the future have for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy any information used or disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release of information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:_____

Patient Signature: _____Date: ___/___/___

Parent/Guardian/Patient Designee Signature: _____Date: ___/___/___

Witness Signature: _____ Date: ___/___/___