AMHERST FAMILY PRACTICE
1867 Amherst Street Winchester VA 22601 540-667-8724 FAX 540-662-5638

Authorization for Release of Medical Information

_____ _____
Print patient full name Birth date (Month/Day/Year)

_____ _____
Street address Social security number

_____ _____
City, state, zip code Phone

_____
Parent/Guardian if patient is under 18yrs.

I _____, authorize _____ to release records **to** Amherst Family Practice:
(Patient name)

Dates of_____

___Discharge Summary ___Pathology Reports ____Operative Notes ___Immunizations only
____History & Physical ___Laboratory Reports ___Radiology Reports ___Entire Chart
____Progress Notes ___ECG/EEG/CARDIO CATH ___Last 3 years ___Other_____

_____ I do _____I do NOT authorize release of information related to STD, AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

_____Referral to Specialist _____Insurance _____Workers Comp _____Leaving Practice
_____Legal Investigation _____Disability Determination _____Personal
_____Relocation/Moving _____Other_____

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, 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 authorization 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 Date
Of patients estate////power of attorney must be attached