AUTHORIZATION FOR RELEASE OF INFORMATION

Rockingham Family Physicians
1751 Erickson Avenue
Harrisonburg, VA 22801
Phone: 540-433-3344 ▪ Fax: 540-433-0031

Patient Name: _____

Birth Date: _____ Last 4 of social: _____ Phone Number: _____

RECORDS COMING INTO OUR OFFICE

Facility Name: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Facility Phone: _____ Facility Fax: _____

RECORDS LEAVING OUR OFFICE

Facility Name: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Facility Phone: _____ Facility Fax: _____

Information being released: (check one)
❑ Complete Record ❑ Progress Notes ❑ Labs ❑ X-Ray Reports ❑ Immunizations ❑Other: _____

Purpose of release: (check one)
❑ Changing Physicians ❑ Consultation/Second Opinion ❑ Continuing Care ❑ Self ❑ Legal ❑ Moving

Sensitive Information (check one)
The following health information will:

_____ **Include** all medical, behavioral health, alcohol and/or drug abuse, HIV testing, and/or AIDS information

_____ **Exclude** ☐ Behavioral Health ☐ Alcohol/Drug Abuse ☐ HIV/AIDS Information

- I understand that this consent is voluntary and that I may revoke this authorization that any time by a written, dated, and signed notice addressed to Rockingham Family Physicians, P.C.
- **This consent will expire in one year** from the date signed unless otherwise stated: _____.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- Alcohol, drug, behavioral health, HIV, and/or AIDS information, if present, will be disclosed as I have directed above. I understand this information is protected by federal and state laws and may not be disclosed without authorization or unless required or permitted by law.

☐ **I understand that I will be charged for copies of medical records leaving Rockingham Family Physicians, P.C.**
Charges for copying records are: Handling: $10.00 ▪ First 50 pages: 50 cents per page ▪ After 50 pages: 25 cents per page

_____ _____ _____
Signature of Patient or Authorized Person Date Relationship to Patient