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: _____

City: _____ State: _____ Phone: _____ Fax:_____

RECORDS LEAVING OUR OFFICE

Facility Name: _____

City: _____ State: _____ Phone: _____ 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

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential Health Records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice revocation by the custodian of the health records.
- There is a potential that information disclosed may be re-disclosed by the recipient and no longer protected by law.
- A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original records. A copy of this Authorization must be kept by this facility for six (6) years.
- **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).
- If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

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