142 Linden Drive, Suite 106
Winchester, VA 22601

Phone: (540) 722 - 7282
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: _____ / _____ /_____ **SHNS ACCOUNT NUMBER:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____ / _____ / _____

ADDRESS: _____ **CITY**: _____ **STATE/ZIP CODE:** _____

PHONE: (_____) _____- _____ **SSN**: _____- _____- _____ / *decline*

Records to be obtained from: _____

Address: _____

Phone #: _____ Fax **#:** _____

Records to be released to*:* _____

Address: _____

Phone #: _____ **Fax #:** _____

Records requested: *please check all that apply*

☐ **Office Notes** ☐ **Pathology Reports** ☐ **Operative Notes** ☐ **Imaging Reports** ☐ **Entire Record**

☐ **Other:** _____

I understand that the information in my health record may include information relating to sexually transmitted diseases and acquired immunodeficiency syndrome/virus (AIDS/HIV). It may also include information about behavioral or mental health services and alcohol and drug abuse/use treatment. I understand that I have the right to revoke this authorization at any time. I also understand that if I revoke this authorization, I must do so in ***writing*** and present my written revocation to the front office staff. I understand that my written revocation will not apply to the information that has already been released in response to previously signed authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under the agreed policy between self and insurer. Unless otherwise revoked, this authorization will expire on the specified date of: _____/_____/**20_____. If I fail to specify an expiration date, this authorization will expire in 12 months.** I understand that authorizing the disclosure of this health information is voluntary. I have the right to REFUSE to sign this authorization. I am not obligated to sign this form in order to ensure treatment. I understand that I may inspect a copy of the information to be used/disclosed, as provided in CFR 164.524. I also understand that any disclosure of my information carries the potential for an unauthorized re-disclosure and the information may not be protected under Federal Confidentiality Rules. If I have questions/concerns about the disclosure of my health information, I can contact the Front Office Manager of SHNS at **(540) 722-7282.**

Patient's Signature Parent *or* Legal Representative: _____

If patient is a minor Records Released by: _____ Relation: _____

OFFICE USE ONLY

Released/Reviewed by: _____ Date: _____ / _____ / _____