AUTHORIZATION FOR RELEASE OF INFORMATION

420 S. Main Street, Suite A • Emporia, VA 23847
9568 Kings Charter Drive, Suite 204* Ashland, VA 23009
804-533-5616 office * 804-533-2311

Patient Name	DOB
Phone Number	SSN (Optional)
Address	City/State/Zip
Email Address	

I AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION

FROM Provider/Facility	TO Provider/Facility
Phone/Fax	Phone/Fax
Address	Address

RECORDS REQUESTED

☐ Complete Medical Record ☐ Office Notes ☐ Medication List ☐ Lab Results ☐ Imaging Reports ☐ Psychiatric Records ☐ Billing Records ☐ Other: ________________

PURPOSE OF DISCLOSURE

☐ Continuity of Care ☐ VA Claim ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other: _________

I understand this authorization may include mental health, psychiatric, substance use, HIV/AIDS, and sexually transmitted disease information if applicable. I understand I may revoke this authorization in writing at any time except to the extent action has already been taken in reliance upon it. This authorization expires one year from the signature date unless otherwise specified.

Patient Signature	Date
Representative Signature (if applicable)	Relationship to Patient
Witness/Staff Initials (Optional)	