Virginia Interventional Spine Associates
4710 Spotsylvania Pkwy, Ste. 201, Fredericksburg, VA 22407
PHONE: 540-374-3233 FAX: 540-371-1662

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____ **(Print patients full name)**

_________________________________ **Birth date (Mo/Day/Yr)**

____ **(Street address)**

_________________________________ **Social security number**

____ **(City, state, zip code)**

_________________________________ **Phone (Home)**

____ **(Parent/Guardian if Patient<18 yrs)**

_________________________________ **Chart #**

At the request of the individual, I _________________________, do hereby authorize ______________________to release:
(Patients Name) (Name of Facility)

SERVICE DATES OF____

______OPERATIVE NOTES
______PROGRESS NOTES
______DISCHARGE SUMMARY
_______RADIOLOGY REPORTS
_______LABRATORY REPORTS
_______PATHOLOGY REPORTS
________ENTIRE CHART
________SPECIFIC INJURY____________________
____

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

INFORMATION RELEASED TO:

____
Name of Company/Agency/Facility/Person

____
Street address

____
City, state, zip

PURPOSE OF DISCLOSURE:

______REFERRAL TO SPECIALIST ______INSURANCE ______WORKERS COMP ______LEAVING PRACTICE
______LEGAL INVESTIGATION ______DISABILITY DETERMINATION ______PERSONAL ______RELOCATION/MOVING
OTHER (SPECIFY)____

Please provide current telephone number in the event we need to contact you: _______________________________

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 or 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.

NOTE: Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

____ _________________________

Signature of individual or guardian or **Date**
Personal Representative of patient's estate Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE_______ LAB_________ EKG____________
DS___________ EKG_________ IMMUNE________
OP___________ X-Ray________ OTHER________________________
HP___________ PATH________ ________________________________

____
ROI SPECIALIST

____
DATE

Revised 02.2012