



Albemarle Endocrinology, PLC
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AUTHORIZATION FOR RELEASE OF INFORMATION

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I (Name) authorize (Facility/Hospital name) to release the information

below to address: at the following

- Discharge Summary, History and Physical Exam, Laboratory Report, Radiology Report, Path Report, ER Report, Consultation Report, Operative Report, Entire Record, Billing & Payment History, Other

Dates of Service:

Patient Name:

Date of Birth: Social Security Number (optional):

Phone Number H: W:

Purpose of request: Personal use, Continuing Care, Other

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include if applicable, PSYCHIATRIC, DRUG/ALCOHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

Special Instructions: (none if blank)

Signature of Patient or Legal Representative Date

Legal representative, indicate relationship to patient

Identification verified

Requesting Unit/Department

This Authorization is only valid for the information/ Purpose(s) indicated above, and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.