Authorization to Release Confidential Medical Information

I, _____DOB _____SSN (last four) _____
Phone number_____Address_____

- ❑ **Check this to authorize About Women OB/GYN to release the information specified below, in accordance with the laws of Commonwealth of Virginia and About Women OB/GYN, to the party identified below:**
- ❑ **Check this to request and authorize the party identified below to release the specified information to About Women OB/GYN, 2296 Opitz Blvd, Suite 440, Woodbridge, VA 22191 (FAX) 703-878-3933**

Name: _____
Doctor's Name or Group Name

Organization: _____

Fax #: _____Phone_____

Address _____

Information to be released

☐ Physician's Progress Notes ☐ Radiology Reports ☐ Final Discharge Summary
☐ Psychiatric Reports ☐ History & Physical ☐ Drug & alcohol
☐ Laboratory Results ☐ HIV Reports Dates of service _____to_____
☐ Other: (please specify) _____

The Purpose for the Disclosure of the Above Information Is:

☐ Continual Care ☐ I'll be returning to About Women OB/GYN ☐ I'm transferring care to: _____
☐ Personal Use
Other:_____

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS 0.50 per page for the first 50 pages and 0.25 per page thereafter.
I hereby authorize, allow and cause the release of information indicated above. No threat of utter coercive measure have induced me to sign this form and I do release About Women OB/GYN from and covenant not to sue About Women OB/GYN for any claim I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligible benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except when actions have already been taken on the bias of this release, If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:

Patient signature:_____**Date:**_____

Parent/Guardian/Patient Designee signature: _____**Date:** _____

Authority of Individual signing for patient: _____

Witness signature: _____
Payment is expected at the time you pick up your records or prior to mailing request. Please allow 10 business days to process your request.