



Authorization to Release Confidential Medical Information

I, _____ DOB _____ SSN _____
Phone number _____ Address _____

- 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:
- 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.