MetroHealth Internal Medicine, PC

Authorization to Release Confidential Medical Information

I, ______________________________________ DOB: _______________ SSN: ______________________

Phone Number: _____________________ Address: ____

____ Authorize MetroHealth Internal Medicine, PC, to release the information specified here, in accordance with the laws of Commonwealth of Virginia, to the party identified below.

____Authorize the party identified below to release the information specified here, to MetroHealth Internal Medicine, PC, 2765 Jefferson Davis Highway, Suite 109, Stafford VA 22554, **Fax (540) 318-8165**

Doctor/Practice: ____

Address: ____

Phone: _____________________________________ Fax: _______________________________________

Information to be released

____Physician's evaluation notes from____

____Radiology Reports ____Laboratory Reports

____Discharge Summary ____ER evaluation notes

____Other ____

Purpose for the release of information

____Continuing care ____Transfer of care

____Personal Use: ____

VA law allows for copy charges consisting of: $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 or utter coercive measure have induced me to sign this form and I do release MetroHealth Internal Medicine, PC from and covenant not to sue MetroHealth Internal Medicine, PC 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 eligible services. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed 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 basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below.

Patient's Signature ____ Date: _______________

Guardian/Patient's Designee Signature: ___________________________________ Date: _______________

Witness Signature: ____Date: _______________

Payment is expected when you pick up your records or prior to mailing your request. Allow 10 business days to process.