

Leesburg Sterling Family Practice
(A Loudoun Medical Group Office)
Telephone (703)724-7530 fax (703)858-2870
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient full name

_____/_____/_____
Birth date

Street address

last 4 digits of Social Security Number
(_____)_____-_____

City/State/Zip

Home telephone

I do hereby authorize _____ to release:
(Practice/institution name)

_____ Progress Notes	_____ Pathology Reports	_____ Emergency Reports
_____ History & Physical	_____ Laboratory Reports	_____ Other _____
_____ Discharge Summary	_____ Radiology Reports	_____
_____ Operative Notes	_____ ECG/EEG/Cardiac Cath	_____

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.

WHERE TO SEND RECORDS: _____
Name of Company/Agency/facility/Person

Street Address

City/State/Zip

PURPOSE OF DISCLOSURE:

_____ Referral to specialist	_____ Insurance	_____ Workers Comp	_____ Change of Doctor/Provider
_____ Legal Investigation	_____ Disability determination	_____ Personal	_____ Continuing care

Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home or work or cell) (_____) _____ - _____

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.

**Signature of individual, guardian or
Personal Representative of patient's estate**

Date

NOTE: There may be a charge for a personal copy or the permanent transfer of your records.