Potomac Physical Medicine 113 N. Henry St. Alexandria, VA 22314 (571) 982-3354 (571) 982-3356 **Staff@potomacphysicalmedicine.com**	**Authorization to Release Protected Health Information**	**For Office Use Only** PHI: □ Mailed □ Picked Up □ Faxed ID Verified: □ Yes □ No Date Received: _____ Date Processed: _____ Processed By: _____

Please complete this form in its entirety so that we may fulfill your request promptly.

Patient's Name: _____ **Date of Birth:** _____

Street Address: _____

City/State/Zip: _____

Telephone #: _____ **Fax#:** _____

Email Address: _____

Authorization for use/disclosure of information:

I am the patient, or legally authorized representative of the patient, listed above. I voluntarily authorize and direct my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below:

□ **Myself**

□ **Another Individual:** _____

□ **Facility/Company/Organization:** _____

Street Address: _____

City/State/Zip: _____

Telephone#: _____ **Fax#:** _____

Email Address: _____

Purpose of Disclosure:

I understand that the specific purpose of this Authorization is for:

□ **Consultation with or Transfer of Care to Another Health care Provider**

□ **Attorney**

□ **Insurance Company**

□ **Workers' Compensation**

□ **Other (please specify)** _____

Information to be disclosed:

This authorization permits the above provider to disclose the following medical records:

□ **My complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me.**

□ **All of my health information described above except for the following:** _____

_____

□ **Only records for dates of service from** __/__/__ **to** __/__/__

□ **Only records related to a specific event, incident or illness (please describe or indicate date of event, incident or illness)** __

_____

□ **Only the following types of information (please check all that apply):**

- □ **History and Physical**
- □ **Clinic Notes**
- □ **Lab Reports**
- □ **Radiology Reports**
- □ **Radiology Images**
- □ **Billing Information**

Inspect/Copy:
I understand that I have the right to inspect or copy the protected health information to be used or disclosed under this Authorization.

Term:
This Authorization will remain in effect:
□ **From the date of this Authorization until __/__/_____**
□ **Until the Provider fulfills this request.**
□ **Until the following event occurs:_____**
If none of the above are indicated, then this authorization will expire 60 days from the date of signature.

Redisclosure:
I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

Refusal to sign/right to revoke:
I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation:
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to **Potomac Physical Medicine** at **113 N. Henry St. Alexandria, VA 22314**The revocation will be effective immediately upon the clinic's receipt of my written notice, except that the revocation will not have any effect on disclosures that relied upon this Authorization and were made prior to receipt of my written revocation.

Questions:
I may contact **Potomac Physical Medicine** with questions about the privacy of my health information at **113 N. Henry St. Alexandria, VA 22314**, by telephone at **(571) 982-3354**, or by email at Staff@potomacphysicalmedicine.com.

Signature	**Date**	**Printed Name**

If the patient is unable to sign this Authorization, please complete the information below. By signing this form for someone else, you - as the parent, guardian, a party acting in loco parentis, or legal representative - are indicating that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

Name of Guardian/Representative	**Date**	**Legal Relationship**

Note: This Authorization does not extend to HIV testing or results, psychotherapy notes, or drug or alcohol treatment records that are protected by federal law.