HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFROMATION

PLEASE COMPLETE THIS FORM IN ORDER FOR DR. LARRY SMITH TO* *RECEIVE YOUR MEDICAL RECORDS FROM YOUR PREVIOUS DOCTOR(S)

PATIENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

I HEREBY AUTHORIZE AND REQUEST: (please list doctor's name, city & state, & phone number on the lines below)

_____

_____

_____

_____

_____

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_____

TO RELEASE MEDICAL INFORMATION ABOUT ME INDICATED BELOW TO:

APPOMATTOX MEDICAL CENTER
LARRY F. SMITH, M.D., P.C.
P.O. BOX 666
APPOMATTOX, VA 24522
TELEPHONE: 434-352-3003 **FAX: 434-352-5005**

DOCUMENT REQUESTED:

- ☐ ENTIRE RECORD
- ☐ HISTORY & PHYSICAL
- ☐ E.R. RECORDS
- ☐ PATHOLOGY REPORTS
- ☐ CONSULTATION REPORT
- ☐ OPERATIVE REPORTS
- ☐ LABORATORY RESULTS
- ☐ EKG TRACINGS & REPORTS
- ☐ RADIOLOGY REPORTS
- ☐ ANESTHESIA RECORDS
- ☐ STRESS TEST REPORTS
- ☐ DISCHARGE SUMMARY
- ☐ OTHER: _____

DATES OF SERVICE REQUESTED ☐ ALL ☐ LAST VISITS ONLY _____

☐ FROM _____ TO _____

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexual transmittable diseases (including test results

related to HIV/AIDS, and I specifically authorize the release of such information pursuant to this Authorization.

I understand that this Authorization will remain in effect for one-hundred-eight (180) days, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment form Recipient or the requested provider of this information will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.
I understand that State and Federal law may prohibit the recipient from re-disclosing information providing pursuant to this Authorization and that there can be no guarantee by the provider that this information will not be re-disclosed. I hereby release the provider of the requested information from any and all liability related to (i) their reliance upon this Authorization of (ii) the release of information pursuant to this Authorization.

By signing below, I authorize the entity checked above to release medical information about me as requested above.

_____
SIGNATURE OF PATIENT

_____
DATE

If the patient is (i) a minor, the patient's parent should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patent's behalf by signing below:

_____
SIGNATURE OF REPRESENTATIVE

_____
DATE

_____ _____
NAME OF REPRESENTATIVE TELEPHONE NUMBER

_____
RELATIONSHIP TO PATIENT

_____ _____ _____ _____
MAILING ADDRESS CITY STATE ZIP

_____ _____ _____ _____
PHYSICAL ADDRESS CITY STATE ZIP