AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THE FEE FOR RECORDS ARE AS FOLLOWS: $20.00 SEARCH AND PROCESSING FEE, $0.37 PER PAGE FOR PAGES 1-50, $0.18 PER PAGE FOR PAGES 51 AND UP

PATIENT'S FULL NAME - ____
DATE OF BIRTH - ___________________________________

STREET ADDRESS ____

CITY, STATE, ZIP CODE ____

DAY TIME PHONE _____________________________
SOCIAL SECURITY NUMBER - _________________________

I, _________________________________ (PATIENT/ GUARDIAN/ LEGAL REPRESENTATIVE),
PLEASE PRINT NAME **CIRCLE RELATIONSHIP**

do hereby authorize,

Hopewell Medical Center 815 W. Poythress St., Hopewell, VA 23860 or
Colonial Heights Medical Center 3512 Boulevard Colonial Heights, VA 23834

to release the following documents regarding ___________________________________

TO:
_____________________________________/_______________________________________
PHYSICIAN/PRACTICE/HOSPITAL **ADDRESS**

____DISCHARGE SUMMARIES	____PATHOLOGY REPORTS	____EMERGENCY REPORTS
____HISTORY & PHYSICALS	____LABORATORY REPORTS	____OTHER_______________
____PROGRESS NOTES	____RADIOLOGY REPORTS	_____________________
____OPERATIVE NOTES	____ECG, EEG, CARDIAC CATH	____ ALL

____ 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.

PURPOSE OF DISCLOSURE:

____ Referral to Specialist	____ Insurance	____Workers Compensation
____ Legal Investigation	____ Disability Determination	____ Personal

I herby 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 persons 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 OR GUARDIAN DATE