POTOMAC FAMILY PRACTICE
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ Print Patient full name

_____/_____/_____ Birth date

_____ Street address

_____-_____-_____ Social Security Number

_____ City/State/Zip

(_____)_____-_____ Home phone number

I do hereby authorize Potomac Family Practice to release these records:

_____Discharge Summary
_____History & Physical
_____Progress Notes
_____Operative Notes
_____Pathology Reports
_____Laboratory Reports
_____Radiology Reports
_____ECG/EEG/Cardiac Cath
_____Emergency Reports
_____Other _____

_____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.

PLEASE RELEASE INFORMATION TO (WHERE THE RECORDS SHOULD BE MAILED):

_____ 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:
(_____)_____-_____

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 or guardian or Personal Representative of patient's estate**

_____ **Date**

NOTE: Our office has contracted with MEDICOPY SERVICES INC. You will receive an invoice from this company that must be paid PRIOR TO your records being mailed to you.
Fees are: Pages 1-50 = $0.50 per page
Pages 51 & up = $0.20 per page
Plus first class postage

224-D Cornwall St. NW • Suite 301
Leesburg, Virginia 20176
(703) 779-0700
Fax: (703) 779-1398

46165 Westlake Drive • Suite 120
Potomac Falls, Virginia 20165
(703) 444-3302
Fax: (703) 444-3240

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____

FAX NUMBER: _____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY MEDICAL RECORDS TO:

POTOMAC FAMILY PRACTICE

46165 WESTLAKE DR.

STE 120

POTOMAC FALLS, VA 20165

PRINT PATIENT NAME: _____

DATE OF BIRTH: _____

SIGNATURE (IF NOT PATIENT, PLEASE STATE RELATIONSHIP): _____

TODAY'S DATE: _____

RECORDS THAT WE RECEIVE FROM ANOTHER INSTITUTION WILL BY LAW BECOME THE PROPERTY OF THE PRACTICE REQUESTING THE SAME. WE RECOMMEND THAT YOU MAKE AN ADDITIONAL COPY FOR YOUR RECORDS WHEN PRESENTING THEM TO POTOMAC FAMILY PRACTICE. ANY RECORDS RECEIVED THROUGH THE MAIL WILL NOT BE COPIED.

NHU-NGA TRUONG, M.D. **JOSEPH LEE, M.D.**