**Medical Records Release Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize release of protected health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information

*To / From* *To / From*

Loudoun Medical Care and Wellness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19450 Deerfield Ave, Suite 400

Lansdowne, VA 20176

Phone: 571-273-5723

FAX: 571-209-1848

The purpose of this disclosure is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ The information you may release subject to this signed release form is as follows:

\_\_\_ Lab Reports \_\_\_ Radiology Reports \_\_\_ Pathology Reports

\_\_\_ Treatment Records \_\_\_ Operative Reports \_\_\_ Hospital Reports \_\_\_ Medication Records \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the use and disclosure of information in my medical record relating to:

(Initial in space provided.)

\_\_\_\_\_ Substance Abuse \_\_\_\_\_ Pregnancy/Contraception/STD \_\_\_\_\_ Psychiatric/Mental Health \_\_\_\_\_ HIV or AIDS

Unless otherwise revoked, this authorization will expire on the following date: \_\_\_\_\_\_\_\_\_\_\_\_.

If I fail to specify an expiration date, this authorization will expire in six months.

**I understand that this authorization can only be revoked in writing by me (the patient) or legal guardian for patient under age of eighteen**

Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_