Patient's Name:____ Account#__________________________

Social Security Number (optional):______________________________ Patient's Date of Birth:_______________

Patient's Telephone Number: (Daytime)__________________________ (Evening)_________________________

I authorize: **FAIRFAX OB-GYN ASSOCIATES, 3650 Joseph Siewick Drive, Suite 203, Fairfax, VA 22033**
To release or disclose the following information to:

____ _______________________________________
Name of Person, Physician or Agency to receive information (Fax number for physician office only)

____
Street Address City State Zip Code

Information to be Released/Disclosed: **DATE(S) OF SERVICE:**___________________________________

() Emergency Record
() Face Sheet
() Discharge Summary
() Psychiatric Admit Note
() Psychiatric Evaluation
() Consultation
() History & Physical
() X-ray Report
() Progress Notes
() Lab / EKG
() Operative Report
() Physicians Orders
() Other________________
() Billing Information
() Substance Abuse Records
() Plan of Care (HH)
() Complete Health Record
() Medical Abstract
() X-ray films/CD

Purpose: Please indicate reason for record transfer:
() Changing doctor because____________________ () Moving () Insurance Changed to_________________
() Dissatisfaction with service. If so, please comment:____
() Other, please explain____

Patient Advised of Charges () Yes () No () N/A
NOTE: Virginia Code 8.01-413B requires that records be provided within 15 days for a charge not to exceed fifty cents per page for the first 50 pages and twenty-five cents for each additional page and a fee not to exceed ten dollars for searching, handling and mailing the records. Virginia Code 32.1-127.1:03 Section J refers to the imposing of fees for copying individual health records. Our cost based fees are the same as listed above.

() I prefer to pick up records () I wish to review records (by appointment only) () Please mail

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand Fairfax OB-GYN Associates, P.C. may not condition treatment on my decision to sign this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

____ ____
Signature of Patient or Representative Date (This authorization will expire 6 months after date signed)

____ ____
Name of Personal Representative (If applicable) Relationship to Patient

Staff/Copy Service Signature:__________________________________ FEE$_______________ () NO FEE

() ID Obtained () Signature Checked () Other TYPE OF ID:____________________________________

Records Released By: ____ Date Released:__________________________