River Valley **Healthcare** Associates

Today's Date:_____

Patient Number:

AUTHORIZATION TO RECEIVE OR SEND MEDICAL RECORDS / INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician'sAddress:_____

Physician's Phone #: _____ Fax # of Physician: _____

Reason for Records Release:_____

These records are to be sent to:

☐ River Valley Healthcare Associates
28 Town Center Drive, Dublin, VA 24084 **Ph:** 540.835.0500 **Fax:** 540.307.5070

☐ Other

Physician's Name: _____

Physician'sAddress:_____

Physician's Phone #: _____ Fax # of Physician: _____

Patient's Name: _____**Date Of Birth:**_____

Address:_____ **State:**_____**ZipCode:**_____

Social Security #: _____ **Phone#:**_____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

_____ X-Ray films (Specify type/date)
_____Immunizations
_____Most recent 3 years of Records
_____Entire Medical Record

_____ Substance and Drug Abuse, if any
_____ AIDS/HIV, if any
_____ Genetic testing, from date
_____Psychological or psychiatric conditions, if any
_____Other _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____ _____

PATIENT SIGNATURE PRINT NAME DATE

_____ _____ _____ _____

PATIENT'S PARENT/GUARDIAN/ REPRESENTATIVE RELATIONSHIP TO PATIENT PRINT NAME DATE