Request for Medical or Financial Record Release

Patient's Name _____Date of Birth_____

Date of Request_____Medical Record Number_____

☐ **I give written permission for my medical records at Front Royal Family Practice to be sent to:**

Doctor/Practice Name:_____
Address:_____City, State, Zip Code_____
Phone Number:_____Fax Number:_____

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **I give written permission for Front Royal Family Practice to obtain my medical records. Please forward my records to:**

Front Royal Family Practice
351 Valley Health Way
Suite 300
Front Royal, VA 22630

Please provide all the following information as to where records should be obtained. Failure to complete this information could delay care. Thank you

Doctor/Practice Name:_____
Address:_____City, State, Zip Code_____
Phone Number:_____Fax Number:_____

☐ **Please check below which of the following information you would like obtained or sent from your records.**

- ☐ All records (includes all options listed below)
- ☐ All records from date of service _____ to _____
- ☐ Recent office note
- ☐ Medication List
- ☐ Behavioral Health
- ☐ Immunization Record
- ☐ Laboratory Results
- ☐ X-Ray/Imaging Results
- ☐ Itemized Bills
- ☐ List of Allergies
- ☐ HIV
- ☐ Other_____

Please Complete Back of Form

For the purpose of continued care. Will you be transferring care? _____
If yes, Why:_____

I understanding that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 (one) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carriers with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

If I have questions about the disclosure of my health information, I can contact the practice privacy office.

Signature of Patient/Guardian_____
Relationship to Patient_____Date_____