Charlottesville Internal Medicine,

A Division of Anchor Healthcare PLC

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Medical Record Release Authorization

Patient Name	Date of Birth

Home Address (P.O. Box or Street, City, State, Zip)	Home Phone
	Cell/Work Phone
	Email Address

A) I hereby authorize records FROM:	
B) To be released TO:	CHARLOTTESVILLE INTERNAL MEDICINE 1410 INCARNATION DRIVE, SUITE 205A CHARLOTTESVILLE, VA 22901 Phone: 434.284.7650 **Fax: 434.956.4818**

C) This request is being made for the following purpose(s):

Date Range: _____ to _____

☐ Physicians' Office Notes ☐ Cardiology/EKG Reports ☐ Lab/Path Reports

☐ Operative/Procedure Reports ☐ Radiology/XRay/MRI Reports ☐ Other _____

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 assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Date	Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from above date unless I specify an expiration date:	Expiration Date of Authorization