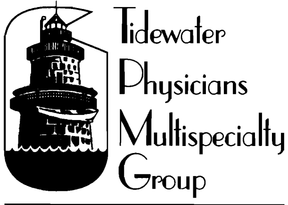

Authorization to Release Medical Information

Please Print Clearly

Patient's Full Name ________________ Chart # ________________

Date of Birth (Month/Day/Year) ________________ Social Security # ________________ Home Telephone ________________

Street Address ________________ City, State, Zip ________________

I, ________________ **do hereby authorize** ________________ **to release:**
Patient's Name

Dates of ________________

- ❑ Complete Medical Record
- ❑ Admission Notes
- ❑ Consultation Notes
- ❑ Discharge Summary
- ❑ ECG/EEG/Cardiac Reports
- ❑ Emergency Reports
- ❑ History & Physical
- ❑ Laboratory Reports
- ❑ Operative Notes
- ❑ Pathology Reports
- ❑ Progress Notes
- ❑ Radiology Reports
- ❑ Other ________________

❑ **I do** ❑ **I do not** Authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release Information to: ________________
Name of Company/Agency/Facility/Person

Street Address ________________ City, State. Zip ________________ Fax # ________________

Purpose of Disclosure:

- ❑ Change of Physician
- ❑ Continuing Care
- ❑ Disability Determination
- ❑ Insurance
- ❑ Legal Investigation
- ❑ Personal
- ❑ Referral to Specialist
- ❑ Workers' Comp
- ❑ Other ________________

I hereby authorize disclosure of health information for the above named patient. This Authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not effect any information released prior to the notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and it would then no longer be protected by federal regulations.

Signature of Individual or Guardian or Personal Representative of Patient's Estate ________________ Date ________________

There is a charge to you for a personal copy or the permanent transfer of your records to entities that are not divisions of Tidewater Physicians Multispecialty Group (TPMG). Hidenwood Technology has been contracted by **TPMG** to provide this service and will invoice the patient directly for **a $ 10.00 processing fee plus $.50/page for the first 50 pages of the medical record, and $.25/page over 50 pages. You will receive a bill for this amount from** Hidenwood Technology. **I have read and understand the above statement and agree to make payment for the cost of copying my medical record.**

Signature of Individual or Guardian or Personal Representative of Patient's Estate ________________ Date ________________

For Office Use Only: ID Verified ________ **Date Records Were Sent** ________________ **Sent By:** ________________