Authorization to Release Confidential Medical Information

I, _____ DOB___/___/____ SSN _____
Address _____ City _____
State _____ Zip Code _____ Phone (_____) _____

( ) I authorize New Beginnings Ob/Gyn, P.C., 2216 Princess Anne St. Suite 202, Fredericksburg, VA 22401 to release the information specified below, in accordance with the laws of Commonwealth of Virginia, and New Beginnings Ob/Gyn, P.C. policies, to the party identified below - or

( ) I authorize the party identified below to release the specified information to New Beginnings Ob/Gyn, P.C., 2216 Princess Anne St. Suite 202, Fredericksburg, VA 22401, (540) 370-4380 – phone, (540) 370-4201 Fax.

Name _____ Fax Number: _____
Organization _____ Phone Number: _____
Street Address _____
City, State, Zip Code _____

Information To Be Released/Obtained

Physician's Progress Notes	_____	Radiology Report	_____
Final Discharge Summary	_____	Consultation	_____
Emergency Room Reports	_____	Psychiatric Records*	_____
Laboratory Results	_____	Drug & Alcohol*	_____
HIV records*	_____		

Other (please specify) _____

Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.

Dates of Service _____ to _____ Medical Record # _____

The purpose for the disclosure of the above information is:
_____ Continuing Care
_____ Personal use
_____ Other _____
(Please designate other purpose)

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Brenda J. Hines, MD from, and covenant not to sue New Beginnings Ob/Gyn,P.C. , the office of Dr. Brenda J. Hines for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:_____

Patient Signature: _____ Date ____/____/____
Parent/Guardian/Patient Designee Signature: _____ Date ____/____/____
Authority of Individual Signing For Patient: _____

Witness Signature: _____ Date ____/____/____