Mail to: Health Information Management 1201B Sam Perry Blvd, Fredericksburg, VA 22401 or fax to: 540-741-1622

☐ I authorize the Mary Washington Medical Group to release the information from the record of:

Patient Name:__________________________ Social Security Number:_________________________

Date of Birth:__________________________ Daytime Phone Number:_________________________

Address:____

Documentation can be released electronically if stored in an electronic media.

Preferred media: ☐ Paper ☐ CD ☐ Online Record eDelivery email address:____________________

Dates of Service:_________________to ____________________

Information to be released:

☐ Complete Medical Record from the Generations of Women Practice

Person/Facility to receive information:____

Street______________________City:___________________State: ______ Zip Code: _____________

This information is being disclosed for the following purpose:___________________________________

Authorization to Release Information:

1. 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure 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 Health Information Management Department at (540) 741-1620.
2. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as:____________________(if none specified, this authorization will expire 6 months after the date specified below).
3. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied at a rate of: $0.12 per page. If delivered electronically, a flat fee of $6.50 will be applied. A copying fee will not be charged if I choose to have the Mary Washington Medical Group forward my records to a new provider.

Signature of Patient or Legal Representative:_____________________________Date:___________

☐ Parent or Legal Guardian ☐ Medical Power of Attorney ☐ Next of Kin Deceased ☐ Executor of Estate

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Department Use Only

MRN______________ ID Verified (Type and ID#)____

Processed By:_______________Date Processed:________________Pages Provided:_________

Mary Washington Healthcare

Mary Washington Medical Group

Authorization to Release Confidential Medical Information

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