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Hampton, Virginia 23666-5843
Phone: (757) 838-6335
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Authorization to Request Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

I authorize:

Facility/Dr./Name:	**Address/Location:**
Telephone/Fax Number:	

to disclose the following information to **Hampton Family Practice** from the medical records of:

Patient Name:	**Date of Birth:**
Telephone Number:	**MRN #**

Dates to be disclosed: ____

This authorization is effective for 1 year from the date of this release unless revoked in writing.

Information to be disclosed:

Previous PCP Medical Records

Please Include ONLY the following information unless otherwise specified.
Most Recent Wellness Exam, Office Visit, EKG, Labs, Bone Density, Mammogram, Colonoscopy, Immunization Record and Growth Chart

Immunization Record	Progress Notes
Laboratory Tests	Diagnostic reports
Consultation Reports	Other ______________________________
Complete Medical Record	

This information is to be released for the purpose of:

Coordination of Care	PCP Request
Personal	Legal Disclosure
Leaving the Practice	Insurance Change
Other: ______________________________	

Hampton Family Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that information in my health record may include behavioral, mental health services or treatment for alcohol and drug abuse. I also understand my health record may include information regarding HIV, AIDS or other sexually transmitted diseases.

____
Signature of Patient or Representative Date

____
Print Name Relationship

Internal Use

Office Staff Signature: ______________________ ***Date Request was Sent:*** ______________________

As the person signing this consent, I understand I have the right to revoke this consent, but my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notification concerning the persons or agencies to which disclosure was made shall be included with original records. The person who received the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent, unless such recipient is a provider who makes a disclosure permitted by law.