HAMPTON FAMILY PRACTICE
*Treating You Like Family*

9 Manhattan Square, Suite A
Hampton, Virginia 23666-5843
Phone: (757) 838-6335
Fax: (757) 838-0612
www.hamptonfamilypractice.com

# Authorization to Release 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 understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

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

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

1. **What treatment dates should be disclosed:** _____
   *This authorization is effective for 1 year from the date of this release unless revoked in writing.*

2. **What health information should be disclosed?**

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

3. **This information is to be disclosed for the purpose of:**
   ❑ Coordination of Care ❑ PCP Request
   ❑ Personal ❑ Legal Disclosure
   ❑ Leaving the Practice ❑ Insurance Change
   ❑ Other: _____

4. **This information may be released to:**

| **Name:** | **Address/Location:** |
|---|---|
| **Telephone Number:** | |

5. **How would I like the records to be released**?

❑ Paper Copy Processing/$10.00 and 1-50 pages: $0.50/page Additional Pages: $0.25/page
❑ Electronic Copy (CD)/$10.00 flat fee ❑ Send to the patient portal
❑ Authorization for oral communication ❑ Other _____
❑ Mailed or Faxed to the address on the request

**Please allow up to 14 days to process your request.**

***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:*** _____ ***Completion Date:*** _____ ***PHI Log: Yes No Initials:*** _____

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.