LOUDOUN COMMUNITY MIDWIVES

19465 Deerfield Avenue, Suite 205
Lansdowne, Virginia 20176
(703) 726-1300 phone
(703) 726-9612 FAX

Authorization for Release of Medical Information

Print Patient's Full Name _____ Birth Date (mm/dd/yyyy) _____

Street Address _____ Social Security Number _____

City / State / Zip _____ Phone Number: Home Cell Other _____

I do hereby authorize the disclosure of the health information for the above-named patient to Loudoun Community Midwives. 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 affect any information released prior to 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 would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I do _____ **I do not** _____ authorize 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.

SIGNATURE of PATIENT (or guardian, or Personal Representative of patient's estate) _____ **DATE** _____ PRINTED NAME (if signature is not of patient) _____ RELATIONSHIP (if signature is not of patient) _____

NOTE: There may be a charge for a personal copy or the permanent transfer of your records as follows: a $10 base fee, $0.50 per page for pages 1-50, then $0.25 for any pages over 50.

FOR OFFICE USE ONLY

INFORMATION REQUESTED FROM: _____ Name of Practice or Practitioner _____ FAX Number

INFORMATION REQUESTED:

_____ Discharge Summary	_____ Laboratory Reports	_____ Progress Notes
_____ ECG/EEG/Cardiac Cath	_____ OB Records	_____ Radiology Reports
_____ Emergency Reports	_____ Operative Notes	_____ Sonogram Reports
_____ History & Physical	_____ Pathology Reports	_____ Other (please specify) _____

PURPOSE OF DISCLOSURE:

_____ Change of Doctor/Provider	_____ Insurance	_____ Referral to Specialist
_____ Continuing Care	_____ Legal Investigation	_____ Workers Comp
_____ Disability Determination	_____ Personal	_____ Other (please specify) _____

_____ Signature of Requesting Practitioner, Title _____ Date

INFORMATION RELEASE TO:

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Lansdowne, VA 20176
FAX: (703) 726-9612