## CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

I-Patient/Parent/Guardian____________________________ DOB___/___/___ SSN_____________

_________________________________________________________ (______)_________________

Address City,State,Zip Phone

___Authorize Colonial Internal Medicine Assoc., 125 Olde Greenwich Dr. Ste 300, Fredericksburg, VA 22408/329 Garrisonville Rd., Ste 106, Stafford, VA 22554, to release the information specified below, in accordance with the laws of the Commonwealth of Virginia, and Colonial Internal Medicine Assoc., PC policies, to the party identified below.

___Authorize the party identified below to release the specified information to Colonial Internal Medicine Assoc., 125 Olde Greenwich Dr. Ste 300, Fredericksburg, VA 22408/329 Garrisonville Rd., Ste 106, Stafford VA, 22554.

**Phone: 540-374-5599**

RELEASE OF INFORMATION TO PERSON/ORGANIZATION AS NOTED BELOW

Name:_________________________________________________________________

Organization:___________________________________________________________

Street Address:_________________________________________________________

City, State, Zip Code:___________________________________________________

Fax Number:____________________________________________________________

### INFORMATION TO BE RELEASED

| | | | |
|---|---|---|---|
| Physician’s Progress Notes | _____ | Radiology Report | _____ |
| Final Discharge Summary | _____ | Consultation | _____ |
| Emergency Room Report | _____ | Complete Chart | _____ |
| History and Physical | _____ | Psychiatric Records | _____ |
| Laboratory Results | _____ | Drug and Alcohol Records | _____ |

Other (specify) ____________________________________________________________

Date(s) of Service: ________________________________ Medical Record Number: _____________

The purpose(s) for the disclosure of the above information is:

_____ Continuing Care

_____ Personal use. I understand that I will be charged a $10.00 search and retrieval fee PLUS $0.50 per page for this service up to 50 pages, and $0.25 per page thereafter.

_____ Other: ___________________________________________________________

I hereby voluntarily authorize, allow, and cause the release of information indicated above. No threat of other coercive measures have induced me to sign this consent form, and I do hereby release Colonial Internal Medicine Assoc., PC from all legal liability that may arise from the release of the information requested.

This information may be disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I 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 document will be null and void 6 months after the date of this document, or on the date, event or condition specifically described as:

_____________________________________________________

_____________________________________________ _____________________________________________

Patient Signature Date Witness Signature Date

_____________________________________________

Parent/Guardian Signature Date

**Please mail medical records to the office.**
**Do not fax.**