

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

_____	_____
(Print patients full name)	Birth date (Mo/Day/Yr)
_____	_____
(Street address)	Social security number
_____	_____
(City, state, zip code)	Phone (Home)

At the request of the individual, I, \_\_\_\_\_, do hereby authorize Mount Vernon Primary Care to release:

\_\_\_\_\_ Please send the following **at no charge**: last 2 office visits, last physical, last lab, last EKG.

\_\_\_\_\_ Please send the following **at my expense** (see charges below):

\_\_\_\_\_ All dates **or** Dates from \_\_\_\_\_ to \_\_\_\_\_.

_____ ALL RECORDS	_____ RADIOLOGY REPORTS	_____ PATHOLOGY REPORTS	_____ HOSPITAL RECORDS
_____ OFFICE NOTES	_____ HISTORY & PHYSICAL	_____ LAB REPORTS	_____ OTHER _____

**INFORMATION  
RELEASE TO:**

\_\_\_\_\_ Name of Company/Agency/Facility/Person

\_\_\_\_\_ Street Address

\_\_\_\_\_ City, State, Zip

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Fax

**PURPOSE OF DISCLOSURE:**

_____ REFERRAL TO SPECIALIST	_____ INSURANCE	_____ WORKERS COMP
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	_____ PERSONAL
_____ CHANGE OF DOCTOR / <b>WILL YOU CONTINUE TO COME TO OUR OFFICE?</b> _____ YES _____ NO		
_____ OTHER (SPECIFY): _____		

**Please provide current telephone number in the event we need to contact you:** \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. 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 effect 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 is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

I hereby understand that by signing this form I am giving authorization to release 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 individual or guardian or Personal Representative of patient's estate** **Date**

**The charts are copied by:**

- **SMART Corporation** who comes to our office every Friday (contracted only to copy charts). You will be billed directly by SMART. Please allow 5 to 10 business days to receive records once they have been copied. SMART's charges are as follows: 50 cents per page for 1<sup>st</sup> 50 pages and 17cents per page thereafter.

**OR**

- **MVPC Medical Records Dept.** (ONLY when time allows us to do so). The charges are as follows: \$10 per chart from 10 to 24 pages (for individuals only) \$15 per chart from 15 to 24 pages (for businesses only) \$25 per chart from 25-100 pages and 15cents per page thereafter (individuals and businesses)

**\*\*If your chart has to be ordered from storage there is an additional \$10 charge for retrieving the chart from Iron Mountain.**