# Rappahannock Family Physicians
# Authorization To Use or Disclose Health Care Information

Patient Name: _____ _____Date of Birth:_____
Patient Address: _____
_____
Patient Primary Phone: _____Social Security Number:_____

**Health Information To Be Disclosed *(required):***
☐ Entire Chart ☐ Labs/Pathology ☐ X-Rays ☐ Shot Record ☐ Physicals
☐ Consults/Hospital ☐ Progress Notes
Include (indicate by initialing): _____Alcohol/Drug Treatment _____HIV Related Info and Test Results _____Mental Health Information
This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Confidential HIV Related Information *only* if I place my initials on the appropriate box(es) above.

**Health Information Period for Disclosure *(required)*.** You may use or disclose information for the following date(s). Check only one:
☐ Most recent pertinent information ☐ Prior 2 years only ☐ Other: _____

**Health Information To Be Released From:**
Organization/Provider Name: _____ _____
Address: _____
_____
Phone Number: _____ Fax Number: _____

**Health Information To be Sent To**:
Organization/Provider Name: _____ _____
Address: _____
_____
Phone Number: _____ Fax Number: _____

**Reason For This Authorization (required). I hereby authorize Rappahannock Family Physicians to discuss and release all related patient health information for the following purpose(s) *(required):***
☐ Personal Use ☐ Legal ☐ Second Opinion ☐ Change in Health Care Provider
☐ Insurance/Billing ☐ Continuous Medical Care ☐ Other: _____
This authorization expires six (6) months from the date signed or earlier if revoked by me (indicate exp. date) _____

**Format of Medical Records (*required*) – see charges on reverse side:**
☐ CD (if available) ☐ Paper copy

**My Rights**:
- I understand that I have a right to revoke this authorization in writing at any time in writing a letter to RFP. However, the revocation may not apply:
  - When RFP has already taken action based on authorization, or
  - Where authorization was required for my insurance coverage
- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
  - To take part in a research study
  - To receive health care when the propose is to create health care information for a third party.
- I further understand that once my health information has been disclosed by RFP, the person or organization that received it may re-disclose it and I will no longer be protected under the health privacy laws.
- If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information.

_X_____ _____X_____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed behalf of the patient Relationship to patient

Regulations of the Board (18VAC85-20-26) state that practitioners must maintain a patient's record for a minimum of six years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, must be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient's encounter regardless of the age of the child;
2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or
3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

After October 19, 2005, practitioners must post information or in some manner inform all patients concerning the time frame for records retention and destruction. Patient records can only be destroyed in a manner that protect patient confidentially, such as by incineration or shredding. For more information, visit the Virginia Department of Health Professions at: www.dhp.virginia.gov/Medicine.

**Payment is expected prior to receiving the records. Please allow 7-10 business days to process.**

***Office Use Only***

| | | | |
|---|---|---|---|
| Attorney/Court | $.50 each page up to 50 pages | # of pages: | = $ |
| | $.25 a page thereafter | # of pages: | = $ |
| | Postage | | = $ |
| | | | |
| Doctor's Office | No charge | # of pages: | No charge |
| | | | |
| Personal Use | $7.50 Electronic/CD Format | # of pages: | = $ |
| | Postage | | **= $** |
| | $10.00 Zeta Faxed | # of pages: | = $ |
| | $10.00 Patient Pick Up | # of pages: | = $ |

*If the patient is not known to the clerk, a photo id with signature **MUST** be verified.*

Photo Id and Signature Verified (what form of Id was used): _____

Request Processed On (date): _____

Completed By Medical Records Clerk (First Name and Last) _____

**********

Amount of Payment Collected: _____

Payment Collected By: (First Name and Last) _____

Date of Posted Payment (Pay to Account) _____