Rappahannock Family Physicians

Permission To Release Information Form

In order for Rappahannock Family Physicians to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by Rappahannock Family Physicians which relate to your past, present or future physical health, and payment for health care. Rappahannock Family Physicians may not use or disclose PHI to persons other than those you specify on this form. There may be special circumstances when you want your PHI communicated to a third party.

_____
Name of Patient (Please Print)

Authorized Person(s)

I authorize Rappahannock Family Physicians to disclose (PHI) to the following person(s): You must specify the name of the person(s).

☐ Spouse _____ Phone Number _____

☐ Child _____ Phone Number _____

☐ Attorney _____ Phone Number _____

☐ Other Person (s) _____ Phone Number _____

☐ Answering Machine _____ Phone Number _____

Validity of Form

Rappahannock Family Physicians will retain this Authorization form in your file. This form is valid until: (Please choose one of the following)

☐ One year from the date I signed this form
☐ The date Rappahannock Family Physicians receives my Cancellation of Authorization Form
☐ _____(provide your own expiration date)

I have the right to revoke this form at anytime by submitting a cancellation of authorization in writing to Rappahannock Family Physicians.

_____ _____
Your Signature (or Signature of Guarantor) Date

_____
Your Name Printed

This form does not authorize a release of your medical records. A Medical Records Release Authorization Form will need to be filled out to release your file to a third party if necessary.