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: please check which office

○ **Fredericksburg**	○ **North Stafford**	○ **Spotsylvania**	○ **Chatham**
120 Executive Center Parkway	422 Garrisonville Road	10502 Rhoads Drive	418 Chatham Square Office Park
Fredericksburg, VA 22401	Suite 102	Fredericksburg, VA 22407	Fredericksburg, VA 22405
PH 540-374-5200	PH 540-657-4800	PH 540-710-9100	PH 540-371-4700
Fax 540-374-1164	Fax 540-657-4021	Fax 540-710-9065	Fax 540-373-0942

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: ______________________________________

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.

____ ____
Patient or legally authorized individual signature Date

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