Churchland Family Medicine, P.C.
3235 Academy Avenue, Suite 101
Portsmouth, VA 23703
Phone: 757-484-7386 Fax: 757-484-1913

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patient Full Name) **(Date of Birth)**

_____ _____
(Street Address) **(Social Security Number)**

_____ _____
(City, State, Zip Code) **(Phone)**

I Hereby Request & Authorize;

Name: _____
Address: _____
_____

To Release My Medical Record To:

_____Frederick C. Crum, M.D. _____David H. Cyr, D.O. _____Margaret M. Stiles, M.D.

_____Progress Notes _____Pathology Reports _____Emergency Reports

_____History & Physical _____Laboratory Reports _____Other _____

_____Complete Record _____

_____I do _____I do not authorize release of information related to AIDS/HIV infection, psychiatric care and/or psychological assessment, treatment of alcohol and/or drug abuse

Purpose of Disclosure;

____Referral to Specialist _____Insurance _____Worker's Comp _____Change of Doctor
_____Legal Investigation _____Personal _____Disability _____Continuing Care

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 affect any information released prior to notification. I understand that the information used or disclosed may be subject to re-disclosure by the person receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition his/her treatment of me on whether or not I sign this authorization.

_____ _____
Signature of Individual or Guardian or Personal Representative of Patient's Estate **Date**