

Premier Primary Care Physicians
200 N. Glebe Road, Suite 300
Arlington, VA 22203
Tel: 703-243-1300 Fax: 703-243-1151

Authorization for Release/Request of Medical Information

(Print patients full name) Birth Date (Mo/Day/Yr) _____

Street Address Social Security Number _____

City, State, Zip Code Phone number (home) _____

____ Discharge Summary ____ Pathology Reports ____ Emergency Reports
____ History and Physical ____ Laboratory Reports ____ All Records
____ Progress Notes ____ Radiology Report ____ Specific Dates Treatment _____
____ Operative Notes ____ ECG/EEG/Cardiac Cath ____ Other _____

____ I DO ____ I do NOT Authorize release of 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.

AUTHORIZE RELEASE OF INFORMATION TO / FROM (CIRCLE ONE)

Name of Company/Agency/Facility/Person

Street Address

City, state, zip

Purpose of Disclosure:
____ Referral to specialist ____ Insurance ____ Workers Comp ____ Change of Doctor
____ Legal Investigation ____ Disability Determination ____ Personal ____ Continuing Care

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 6 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/ furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or _____
Personal Representative of patient's estate Date

Note: There will be a charge for a personal copy or the permanent transfer of your records.

Office Use:
Date Sent: _____
Initials: _____