

ASHBURN PEDIATRICS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number

(City, state, zip code)

Phone (home)

At the request of the individual, I _____, do hereby authorize _____ to release:
(patients name) (name of facility)

- | | | |
|---|--|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> RADIOLOGY REPORTS | _____ |
| <input type="checkbox"/> OPERATIVE NOTES | <input type="checkbox"/> ECG/EEG/CARDIC CATH | _____ |

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.

THE RECORDS WILL NOT BE MAILED UNTIL THE INVOICE FROM SMART CORP IS PAID.

INFORMATION RELEASE TO: _____
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
OTHER (SPECIFY) _____

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 12 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 is 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: VA STATE LAWS PERMIT A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS. THIS FACILITY HAS CONTRACTED WITH THE SMART CORPORATION TO MAKE COPIES. THE COPIES WILL BE MAILED ALONG WITH WITH AN INVOICE (IF THE FEE IS APPLICABLE).

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE _____	LAB _____	EKG _____	_____
DS _____	EKG _____	IMMUNE _____	_____
OP _____	X-Ray _____	OTHER _____	ROI SPECIALIST _____
HP _____	PATH _____		DATE _____ NUMBER OF PAGES _____

THE RECORDS WILL NOT BE MAILED UNTIL THE INVOICE FROM SMART CORP IS PAID