Shimla Medical Center

9306 Forest Point Circle
Manassas, VA 20110
Phone: 703-330-3322
Fax: 703-330-5051

10560 Main Street, Suite 210
Fairfax, VA 22030
Phone: 703-273-3613
Fax: 703-273-9676

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO MY PRIMARY PHYSICIAN

ALL SECTIONS MUST BE COMPLETED

RELEASE HEALTH INFORMATION

RELEASE HEALTH INFORMATION FROM:

NAME/ TITLE/ ORGANIZATION: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ DATE(S) OF SERVICE: _____

I authorize "the entity stated above" to release the above named individual's health information as described below:

1. The type and amount of information to be used or disclosed is as follows:

○ History and Physical*	○ Consultation Report*	○ Complete Chart*
○ Operative Note*	○ Laboratory Results*	○ HIV Records*
○ Pathology Report*	○ Nurses' Note*	○ Other
○ Radiology/Imaging Report*	○ Progress Notes*	
○ EKG Report*	○ Physicians' Orders*	

*I understand that minimum necessary guidelines of HIPAA may apply.
*I have marked the applicable boxes if I am requesting HIV records to be released.
These records will not be released with the "complete chart" unless specifically requested.

2. This information may be used, disclosed to and used by the following organization:

Shimla Medical Center

9306 Forest Point Circle, Manassas, VA 20110
Phone: 703-330-3322
Fax: 703-330-5051

10560 Main Street, Suite 210 Fairfax, VA 22030
Phone: 703-273-3613
Fax: 703-273-9676

3. For the purpose of: At the request of individual Other

4. I understand that the information may be redisclosed by the person or entity indentified above and will no longer be protected by federal privacy regulations. I further understand that I may revoke this consent to release information at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization.

5. Unless otherwise revoked, the authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire six months from the date of signing.

_____ _____
SIGNATURE DATE

_____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS

_____
DATE