Martinsville Henry County Coalition for Health and Wellness

NEW PATIENT Written: 10/2017

Bassett Family Practice | 324 T B Stanley Hwy. | Bassett, VA 24055 | Ph: 276-629-1076 | Fax: 276-629-2695
Ridgeway Family Health | 4944 Greensboro Rd. | Ridgeway, VA 24148 | Ph: 276-956-2233 | Fax: 276-956-1629

AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL RECORDS

Patient name: _____ DOB: _____

Address: _____

Phone Number: _____ SSN: XXX-XX- _____

I release BFP or RFH from all responsibility or liability that may arise from the release or exchange of such records.

Informed consent has been explained to me and I understand the contents to be released, need for information, and that there are statutes and regulations protecting confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and valid until such request is fulfilled **NOT TO EXCEED NINETY (90) DAYS** from the effective date. I further acknowledge that I may revoke this consent at any time either in writing or verbally except to the extent that action based on the consent has been taken.

_____ _____

Patient or Parent/Guardian Signature Effective Date

_____ _____

BFP OR RFH Representative Signature Date

COPY OF ID *(If records are picked up in office)*

Printed by: _____

Reviewed by: _____

TO BE COMPLETED BY OFFICE

Information authorized to be obtained or for release: *(Please check all that apply)*

☐ History & Physical	☐ Progress Notes	☐ Lab results	☐ Medication
☐ Emergency/Urgent Assessment	☐ Admission/Intake	☐ Radiology/MRI/CT	☐ Psychiatric Evaluations
☐ Substance Abuse and/or Treatment	☐ Discharge Summary	☐ Op notes	☐ Pathology report
☐ Immunization records	☐ Entire Chart	☐ Pap Smear Results	

☐ Specific dates: From: _____ To: _____

☐ Other: **MOST CURRENT 12 MONTHS OF PROGRESS NOTES, ALL LABS AND X-RAY RESULTS ON FILE IN YOUR OFFICE**

This information will be used for:	☐ Continuum of Care	☐ Legal	☐ Transfer to another MD
☐ Evaluation/Treatment	☐ Personal Records	☐ Benefits	☐ Employment

☐ Other *(please specify)*: _____

I authorize the use or disclosure of information in my medical record as described below to be provided to or obtained by the following:

☐ **I authorize BFP or RFH to release specified information in my medical record to the following Individual/Facility/ Company:**

Name: _____ Phone: _____

Address: _____ Fax: _____

☐ **I authorize the following Individual//Facility/Company to release specified information in my medical record to RFH:**

Name: _____ Phone: _____

Address: _____ Fax: _____

☐ **I authorize a mutual exchange of information between BFP or RFH and the following agency/person:**

Name: _____ Phone: _____

Address: _____ Fax: _____

I understand that information regarding my alcohol and/or drug treatment records is protected under federal law under the Drug Abuse Prevention, Treatment and Rehabilitations Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and their implementing regulations **See generally 42 C.R>R. Part 2:.45 C.F.R. Parts 160, 164.** I understand that my health information specified above will be disclosed pursuant to this authorization and that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal regulations governing confidentiality of alcohol and drug abuse patient information, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I understand that I may revoke this consent verbally or in writing at any time except to the extent that action has been taken in reliance on it. **ADDRESS:** The program's ability to condition treatment, payment enrollment or eligibility of benefits on the patient agreeing to sign the consent by stating either that the program may not condition these services on the patient signing the consent or the consequences for the patient refusing to sign the consent.

Date Consent Revoked: _____ verbal revocation ___ written revocation ___ Revoked by: _____