MHC Coalition for Health and Wellness
Medical Records Release Authorization

Patient Name (Last, First, Middle Initial) _____ Maiden or Other Name _____

Date of Birth _____ SSN# XXX-XX-_____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

☐ **I hereby authorize** _____ (print name of provider)

Address _____ Phone _____

City, State, Zip _____ Fax _____

to release information from my file as indicated below to:

☐ **Bassett Family Practice**
Send all correspondence to:
324 T B. Stanley Hwy.
Bassett, VA 24055
Phone: 276-403-5090
Fax: 276-629-2695

☐ **Ridgeway Family Health**
Send all correspondence to:
4944 Greensboro Road
Ridgeway, VA 24148
Phone: 276-403-5090
Fax: 276-956-1629

COPY OF PATIENT ID HERE

☐ **I hereby authorize Bassett Family Practice/Ridgeway Family Health to release information from my medical record as indicated below to:** _____

Address, City, State, Zip _____

Phone _____ Fax _____

INFORMATION TO BE RELEASED *(please complete both sections)*

I specifically authorize the release of information relating to:

Yes No
- ☐ ☐ Substance Use Disorder (including alcohol/drug abuse)
- ☐ ☐ Mental Health (including psychotherapy notes)
- ☐ ☐ HIV Related information (AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

DATES
- ☐ History and Physical Exam _____
- ☐ Labs, X-ray Reports _____
- ☐ Other:_____ _____
- _____

Purpose of release: _____Continuation/Coordination of Care, Follow-up treatment or ongoing care

_____ Changing Providers Other: _____

AUTHORIZATION:

- I understand this authorization will expire (90) days after I have signed this form.
- I understand I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified except to the extent action has already been taken.
- I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by either federal or state privacy rules or regulations.
- I hereby release the releasing provider from any liability or responsibility associated with the release of this information in accordance with this authorization.
- I understand that while there is usually no charge for medical records if copies are sent for ongoing care or follow-up treatment, **some facilities charge for transfer of records. The patient is responsible for any charges related to the transfer of records.**

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Health Center Representative Signature Date

FOR OFFICE USE: Date Authorization Processed: _____ Printed by: _____Reviewed by:_____
Date Consent Revoked: _____ ☐ verbal revocation ☐ written revocation Revoked by: _____

[1]Notice to Receiving Party: 42CFR Part 2 may prohibit unauthorized re-disclosure of these records.