Office Use Only
Date Received:
Date Pt. Notified:
Date Picked Up:

CLARKSVILLE PRIMARY CARE CENTER
61 BURLINGTON DR. CLARKSVILLE, VA 23927
PH: 434.374.2773 FAX: 434.374.4202

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Photo ID will be required of any party (including patient) who will be picking up the records

Patients Name: _____ Date of Birth: _____

Mailing Address: _____

Last four digits of Social Sec. # _____ Phone #: ( ) _____

Name of Person to pick-up records (if other then patient) _____

I hereby authorize: _____
Name of Physician/Facility from whom you are requesting records

To release my medical records to _____
Name of Patient/Physician/Facility to whom the records will be sent

Information to be released should include:

☐ Complete Health Record	☐ Office Notes	☐ Consultation Reports
☐ History & Physical Notes	☐ Progress Notes	☐ Lab Test Results
☐ X-ray Films (addt'l fees) * MUST read & initial below	☐ X-Ray Reports	☐ Demographic/Insurance Information
☐ Itemized Bills	☐ Other: *List Here*	☐ Other *List Here*:

Purpose of this Request: ☐ Treatment/Consultation ☐ Patient Request ☐ Billing/Claims Payment

Information to be released: ☐ All dates of service ☐ Date Range: From: _____ To: _____

Unless revoked, this authorization will expire: ☐ 6 months from today ☐ upon processing completion

I, the undersigned, have read and authorize the staff of the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient an will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1998. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I can inspect or copy the protected health information to be used or disclosed except to the extent that action has been taken in compliance with this request.

_____ _____
Signature of Patient / Legal Guardian Date

Initials _____ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually transmitted disease, Hepatitis B or C, HIV Testing, HIV results or AIDS Information.

Initials _____ I acknowledge that I am receiving the original x-ray films and am responsible for returning said films back to Clarksville Primary Care Center within two weeks from today. I understand and accept responsibility that if I fail to return said films Clarksville Primary Care Center will not be held liable for inability to supply x-ray films for any future requests (i.e. Subpoena, doctors office requests, patient requests, etc.)