ADVANCED MEDICAL SPORTS AND SPINE, PLLC
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____
Address & Apt#: _____ City: _____ State: _____ Zip: _____
Phone: Home # _(_____)_____ Cell # _(_____)_____ Work # _(_____)_____

Advanced Medical Sports and Spine, PLLC has my permission to release information contained in the Medical Record of the above named patient.

INFORMATION TO BE RELEASED: Please specify and include date(e.g., procedure/operative note, progress note, radiology report, laboratory report, entire chart) injury_____

_____ 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.

Please document any Restrictions and/or Exclusions (if none, please write none)
_____

PURPOSE OF DISCLOSURE: Please specify (e.g., workers' comp, legal investigation, referral to specialist, leaving practice, relocation, insurance request, disability determination)_____

Advanced Medical Sports and Spine, PLLC will provide the information requested above to the following party:

Name: _____ Attention of: _____
Phone: _(_____)_____ Fax: _(_____)_____
Address & Apt#:_____ City: _____ State: ____ Zip: _____

I hereby authorize Advanced Medical Sports and Spine, PLLC to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Advanced Medical Sports and Spine, PLLC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Advanced Medical Sports and Spine, PLLC may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization is valid for 12 months from the date of signature. I can cancel this authorization in writing at any time, except to the extent that Advanced Medical Sports and Spine, PLLC has relied upon it. For example, if I cancel it after Advanced Medical Sports and Spine, PLLC has sent requested records, Advanced Medical Sports and Spine, PLLC will not retrieve those records. I understand that Advanced Medical Sports and Spine, PLLC will continue to provide care, even if I do not authorize this release.

Please note: Copies from this office's records shall be furnished within fifteen (15) days of request. Virginia Law permits a charge for personal copy / transfer of your records. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS. Charges will be as follows:

- fifty cents per page for up to fifty pages
- twenty-five cents a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process
- one dollar per page for copies from microfilm or other micrographic process plus all postage and shipping costs and a search and handling fee not to exceed ten dollars.

Signature of Patient who is 18 years or older or have emancipated minor status or special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.

_____	_____	_____/_____/_____
Name of Patient	Signature of Patient	Date

_____	_____	_____	____/____/____
Name of Parent or Guardian	Signature of Parent or Guardian	Relationship to Patient	Date