Regional Health Providers
3917 Old Lee Hwy • Suite 11D • Fairfax VA 22030
Tel (703) 691-4000 • Fax (703) 691-4010

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my medical records or copies and request that

- ☐ **Regional Health Providers, LLC**
- ☐ **Name of Physician/Facility: _____**
  - **Ph. Number _____ Fax. Number _____**

Release my records to:

- ☐ **MYSELF**
- ☐ **Regional Health Providers, LLC**
- ☐ **RECIPIENT :**
  - **Name _____ *Relationship to Patient* _____**
  - **Address _____**
  - **Ph. Number _____ Fax Number _____**

Method of Delivery

- ☐ **TELEPHONE / VERBAL**
- ☐ **PICK UP** my records during regular business hours. I understand that there will be a $25 charge for this if more than 5 pages are processed. *Records will be ready within 3-5 business days.*
- ☐ **MAIL** records by certified mail. *I understand there is a $35 charge for this,* to cover postage expenses. If I do not sign for the certified mail and it is returned to RHP, I must pick up my records during regular business hours. *Records will be mailed within 7-10 business days.*
- ☐ **FAX** understand that by having my records faxed, I risk another person viewing my confidential medical information. *If you choose to receive medical records at a company, be aware that some companies use digital fax software, and a copy of the fax is stored in a computer perhaps indefinitely*. I understand there is a $25 charge for this if more than 5 pages are processed. *Records will be ready to fax within 3-5 days*
- ☐ **EMAIL** my records during regular business hours. I understand that there will be a 3 page limit for this option. I also understand that email is NOT A SECURE METHOD OF TRANSMISSION. Emails may not be encrypted or protected.
  - **Email _____ @ _____** *Records will be ready within 3-5 business days.*

Medical Records to be Released *(PLEASE CHOOSE ONE.):*

- ☐ **COMPLETE** History of Medical Records
- ☐ **VERIFICATION of (circle):** Appointments Financial Urine Drug Screen Results
- ☐ **ONLY Medical Records dated from _____ to _____**
- ☐ **OTHER** (PLEASE BE SPECIFIC) _____

I understand that if the person or agency that receives my information is not a healthcare provider or health plan covered by HIPAA privacy regulations, the information described above may be redisclosed, and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization, and can be addressed to the department listed at the bottom of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that RHP may not condition treatment on my decision to sign this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

_____/_____ _____

Signature of Patient **Printed Name** **Date**

_____/_____

Witnessed By **Name and Title**

Official Use Only

Staff Initials: _____ Date:_____

***Please use Medical Records Release Fax Coversheet when faxing.**

Notes:_____