Chickahominy Family Practice, Inc.

New Market Medical Center
2660 New Market Rd
Richmond, VA 23231
Ph. (804)795-1144
Fax (804)795-1052

New Kent Medical Center
1850 Pocahontas Trail
Quinton, VA 23141
Ph. (804)932-4388
Fax (804)932-9860

Providence Forge Medicare
9010 Pocahontas Trail
Providence Forge, VA 23140
Ph. (804)932-4388
Fax (804)966-9712

Authorization to Request/Release Health Information

Patient Information:

Name of Patient ______________________________________ Date of Birth ______________

Address____

City, State, Zip _____________________________Phone ______________________________

At my request the following information may be released:

o Entire record o Office visit notes o On site record review by the patient

o Psychotherapy notes – if this box is checked only psychotherapy notes may be released.

o Diagnostic studies (list):

o Other as listed: HIV/AIDS positive or negative test results

Entity or person to *release* the information:

Name ____

Address____

City, State, Zip ______________________________Phone ___________________________

Entity or person who will *receive* the information:

Name ____

Address____

City, State, Zip ______________________________Phone ___________________________

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I understand that Chickahominy Family Practice, Inc. will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying Chickahominy Family Practice, Inc. in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking. But will be effective going forward.
- I understand that confidential information disclosed pursuant to this authorization is no longer under the control of Chickahominy Family Practice, Inc. and may be subject to re-disclosure by the recipient and no longer protected by federal or state law
- I agree to be responsible for and pay the fee for providing copies of my medical information.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

____ Date ____________________________

Signature of Patient or Personal Representative

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Description of Personal Representative's Authority (attach necessary documentation)