14370 Lee Highway, Suite 105, Gainesville, VA 20155

Gainesville Family Practice, P.C.

Your neighborhood family doctors

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

(Patient full name) ____________________ **(Birth date)** ____________________

(Street Address) ____________________ **(Social Security Number)** ____________________

(City, State, Zip) ____________________ **(Phone Number)** ____________________

At the request of the individual, I____, do hereby authorize

____

(Name and Address of Former Doctor/Facility)

(Phone number) ____________________ **(Fax number)** ____________________

To release the following health information to Gainesville Family Practice:

Dates of Service: ____

____**ALL RECORDS**
____History & Physical
____Laboratory Reports
____Operative Reports
____Office Notes
____Immunizations
____Radiology Reports
____Emergency Reports
____Pathology Reports
____ECG/EEG/Cardiac Cath

___I do ___I do NOT authorize release of information related to AIDs or HIV infection, psychiatric care and or psychological assessment and treatment for alcohol and/or drug abuse.

Release Information to: Gainesville Family Practice, P.C.
14370 Lee Highway, Suite 105
Gainesville, VA 20155
Phone: (703)754-4101 Fax: (703)754-1105

Purpose for disclosure:

____Change of Doctor ____Moved ____Other (specify)

____ ____________

Signature of individual or Guardian or Personal Representative of Patient's Estate **Date**

******NOTE: There may be a charge for a personal copy or the permanent transfer of your records. This request is good for 6 months from date of signature.**