James River Family Practice

Medical Record Release Form

Patient Information:

Name of Patient_____ Date of Birth_____

Name, address, & phone of Covered Entity authorized to release information:

_____

_____

_____

Name & address for mailing or indicate if pick-up by person other than patient – include contact phone number

_____

_____

_____

Description of information to be released/reviewed at the request of the patient:

_____

Reason for the request:_____ If moving please include date:_____

Would you like to speak to the Office Manager: _____Yes _____No

Patient Information

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation if not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the medical practice has the right to deny me access to my records in certain circumstances in accordance with the law. If the medical practice denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

I understand there will be a charge for any and all medical records requested.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____ Date _____

Signature of Patient or Personal Representative

_____ _____

Print or Type Name of Patient or Personal Representative Contact Phone Number

_____

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