AUTHORIZATION FOR RECORDS RELEASE

Patient's Name: ____ Patient's Date of Birth: ___________

Patient's phone number: (______) __________________________ (______) __________________________
DAYTIME EVENING

I authorize____ to release or disclose the following information to:

☐ **Inova Medical Group – ALFA Neurology**
8505 Arlington Blvd, STE 450
Fairfax, VA 22031
Tel: 703-280-1234 Fax: 703-280-1235

☐ **Inova Medical Group – ALFA Neurology**
1500 N. Beauregard Street, STE 300
Alexandria, VA 22311
Tel: 703-845-1500 Fax: 703-845-1300

Information to be Released / Disclosed:

❑ Pathology ❑ X-ray Report ❑ Other ___________________

❑ Lab / EKG ❑ Office Notes

❑ Hospital/Specialist Reports ❑ Complete Health Record

Purpose:

❑ Medical Follow-Up Individual use Insurance

❑ Attorney ❑ Disability ❑ Other ________________________

❑ **I prefer to pick up records**

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

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top 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 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 OR REPRESENTATIVE

____ DATE (This authorization will expire 6 months after date signed)

____ NAME OF PERSONAL REPRESENTATIVE (IF APPLICABLE)

____ RELATIONSHIP TO PATIENT