

Fairfax Neonatal Associates
Authorization to Use and/or Disclose Protected Health Information

<u>Name & address of health care provider or Practice Site:</u>	<u>To use/disclose medical information to:</u>
<u>Name of provider/clinic</u>	<u>Name</u>
<u>Street address</u>	<u>Street address</u>
<u>City, State, Zip</u>	<u>City, State, Zip</u>
<u>Phone Number</u> <u>Fax Number</u>	<u>Phone Number</u> <u>Fax Number</u>

<u>Patient Name</u> _____	<u>Medical Record Number</u> _____
<u>Date of Birth</u> _____	<u>Date(s) of Service</u> _____
<u>Patients or Personal Representative's Phone Number</u> _____	<u>Purpose of Disclosure</u> _____

By **checking** the space(s) below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

Specify below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Demographic Sheet | <input type="checkbox"/> Pulmonary Function Test | <input type="checkbox"/> Send Entire Medical Record |
| <input type="checkbox"/> Visit/Office Notes | <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Other, describe: _____ |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Pathology Reports | _____ |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing Statement | _____ |
| <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> Sleep Study Results | _____ |

I understand that this disclosure may include information regarding drug or alcohol abuse (as covered in 42 C.F.R. Part 2); psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (as covered in Va. Code 32.1-36.1). **If you agree, initial here:** _____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential medical records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such condition is permitted by law are applicable and are set forth in this authorization.

I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my medical records and is not effective as to medical records already disclosed under this authorization.

I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Unless revoked earlier, this authorization expires **1 year** from the date signed or on _____

<u>Signature of Patient or Patient's Legal Representative</u>	<u>Date of Signature</u>
<u>Print Patient's Name or Name of Legal Representative (if applicable)</u>	<u>Relationship to Patient or Authority of Legal Representation</u>

Patient's or Legal Representative's Personal Identification Verified. Records Copied by: _____

(A copy of this signed form will be provided to the patient or patient's legal representative.)