FNA P.C.
a Neonatal & Pediatric Subspecialty Group

Authorization to Use and/or Disclose Protected Health Information

Information to be released ***From***:

_____
Name of provider/practice

_____
Street address

_____
City, State, Zip

_____
Phone Number Fax Number

Information to be released ***To***:

_____
Name or Name of Organization

_____
Street address

_____
City, State, Zip

_____
Phone Number Fax Number

Patient Name _____ Medical Record Number _____

Date of Birth _____ Date(s) of Service_____

Patient or Personal
Representative's Phone Number_____ Purpose of Disclosure _____

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:

___ Demographic Sheet
___ Visit/Office Notes
___ Consults
___ Laboratory Reports
___ Diagnostic Imaging Reports
___ Pulmonary Function Test
___ Operative Notes
___ Pathology Reports
___ Sleep Study Results
___ Billing Statements
___ Send Entire Medical Record
___ Other, describe: _____
_____
_____
_____

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 I am giving my permission to the above-named health care entity for disclosure of confidential medical records. I understand 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 I have the right to revoke this authorization at any time, but 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 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 _____
_____

_____
Signature of Patient or Patient's Legal Representative

_____
Date of Signature

_____
Print Patient's Name or Name of Legal Representative (if applicable)

_____
Relationship to Patient or Authority of Legal Representation

☐ 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.)

Instructions for completing the
"Authorization to Use and/or Disclose Protected Health Information" form

If you are requesting medical and/or billing records to be released to someone other than yourself, complete all sections of the *Authorization to Use and/or Disclose Protected Health Information* form. This Authorization must be completed, in its entirety, before medical and/or billing records are released.

1. Print the name and address of the FNA health care provider, or practice site, that is to release the medical and/or billing records in the "Information to be released ***From***" section.

2. Print the name and address of the person or entity that is to receive the medical and/or billing records in the "Information to be release ***To***" section.

3. Print the name of the patient, including middle initial.

4. Print the patient's medical record number, if known.

5. Print the patient's date of birth.

6. Print the date(s) of service of the health care information you would like released. If you do not know the specific dates of service, provide a date range.

7. Print your phone number where a staff member may contact you should there be any questions regarding your request.

8. Print the reason or purpose for the disclosure of medical and/or billing information.

9. Check ✓ the space next to each type of records you wish to disclose to the recipient. If you do not see the type of record you wish to disclose, please describe it in the space "Other, describe".

10. Read and initial (if you agree) to disclose specially protected health information (such as drug or alcohol abuse, psychiatric or mental illness or HIV/AIDS).

11. Fill in an expiration date or expiration event. If this is left blank, the Authorization will expire 1 year from the date the form is signed.

12. On the signature line, sign your name if you are the patient or patient's legal representative.

13. Print today's date.

14. Print the patient's name or your name if you are the patient's legal representative.

15. Print your relationship to the patient if you are not the patient.

16. Retain a copy of the completed Authorization form for your records.

If you have questions about releasing patient medical records, please call the outpatient site where services were received. You may fax your completed Authorization to the site where services were received. If you have questions regarding patient billing records only, call Management Consultants for Affiliated Physicians, Inc. (MCAP) at (703) 289-1400 to speak with a billing representative.

Fairfax Neonatal Associates Phone: (703) 289-1400 Fax: (703) 289-1414	**The Pediatric Lung Center & Allergy** Phone: (703) 289-1410 Fax: (703) 289-1420
Pediatric Infectious Disease Group Phone: (703) 226-2280 Fax: (703) 752-1713	**Pediatric Surgical Group** Phone: (703) 560-2236 Fax: (703) 876-4960
Pediatric Sleep Center Phone: (703) 226-2290 Fax: (540) 751-1954	