Fairfax Neonatal Associates

# Authorization to Use and/or Disclose Protected Health Information

**Information to be released *From*: Check ✓ the appropriate site for the records request.**

| | | |
|---|---|---|
| ❒ Fairfax Neonatal Associates (**FNA**) | ❒ The Pediatric Lung and Allergy Center (**PLAC**) | |
| ❒ Pediatric and Adolescent Sleep Center (**PASC**) | ❒ Pediatric Surgical Group (**PSG**) | ❒ Pediatric Infectious Disease Group (**PIDG**) |

**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/Patient Representative Phone**: | **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:

**REQUIRED: Date(s) or date range of service you are requesting:** ❒ Last visit note ❒ Last 3 visit notes ❒_____

❒ Visit/Office Notes ❒ Diagnostic Imaging Reports ❒ Sleep Study Results ❒ Other, describe: _____
❒ Consults ❒ Pulmonary Function Test ❒ Pathology Report _____
❒ Laboratory Reports ❒ Operative Notes ❒ Billing Statement _____

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 Processed 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 and patient's date of birth

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

5. 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.

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

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

8. 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".

9. 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).

10. 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.

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

12. Print today's date.

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

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

15. 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 practice where services were received. If you have questions regarding patient billing records only, call Fairfax Neonatal Associates, P.C. Billing Office at (703) 289-1450 to speak with a billing representative.

| | |
|---|---|
| **Fairfax Neonatal Associates, P.C.**<br>Phone: (703) 289-1400<br>Fax: (703) 289-1414 | **Pediatric Lung and Allergy Center**<br>**(Practice closed 10/22/21)**<br>Phone (703) 289-1410<br>Fax: (855) 208-6428 |
| **Pediatric Infectious Disease Group**<br>**(Practice closed 09/2014)**<br>Phone: (703) 289-1400 · Fax: (703) 289-1414 | **Pediatric Surgical Group (practice closed 5/16/22)**<br>Call Phone: (703) 560-2236 for medical records |
| **Pediatric and Adolescent Sleep Center**<br>**(Practice closed 8/2/22)**<br>Call Phone: (703) 226-2290 for records | |