FAUQUIER FREE CLINIC, INC.
P.O. Box 3138, Warrenton, VA 20188
(540) 347-0394 Fax: (540) 349-3262

AUTHORIZATION TO RELEASE AND/OR RECEIVE PATIENT INFORMATION

_____ _____
Patient's Full Name Birth Date (mm/dd/yyyy)

_____
Social Security Number

I _____ , hereby authorize the **Fauquier Free Clinic, Inc.** to

☐ Discuss information with ☐ Release information to ☐ Receive information from:

_____
Name of Company/Agency/Facility/Person ("Self" if to the patient) Email

_____
Street Address

_____
City/State/Zip Phone Number Fax Number

For the purpose of: ☐ personal use ☐ or other (please specify) _____

Protected Health Information (PHI) to be released or received:

_____ Entire Medical Record
_____ Medical Treatment
_____ Lab Results (excludes Urine Drug Screen)
_____ X-rays or other Imaging Reports
_____ Dental Treatment
_____ Mental Health Counseling Treatment
_____ Psychiatric Treatment
_____ Urine Drug Screen Results
_____ Substance Abuse Treatment
_____ Court Records
_____ Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
_____ Other (specific records or date range) _____

Patient records requested for personal use may be provided in the format requested. **Unless otherwise specified below I understand my records will be provided on CD for patient pickup.** I hereby request that PHI released to me be provided in the following format:

☐ unencrypted PDF via email ☐ encrypted PDF via email ☐ CD ☐ encrypted USB ☐ paper (for patient pickup)

NOTE: There is some level of risk that a third party could access your Protected Health Information (PHI) without your consent when electronic media or email is requested. We are not responsible for unauthorized access to media or email or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

I hereby authorize disclosure of the indicated health information for the above-named patient. I understand the date this release expires is not to exceed one year from the date this authorization is signed. I understand that I may cancel this request with written notification but that it will not affect any information released prior to receipt of said notification. I understand that the information disclosed may be subject to re-disclosure by the person or persons or facility receiving it and would then no longer be protected by federal regulations.

_____ _____ _____
Signature of Patient OR Parent/Legal Guardian **Printed name of Patient OR Parent/Legal Guardian** **Date**

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

_____ _____ _____
Patient's Legally Authorized Representative **Printed name of Legally Authorized Representative** **Date**