



Authorization to Release Medical Information

Please Print Clearly

Patient's Full Name _____ Account# _____

Date of Birth (Month/Day/Year) _____ Social Security # _____ Home Telephone _____

Street Address _____ City, State, Zip _____

I, _____ Do hereby authorize _____ to release:
Patient's Name

Dates of

- | | | | |
|--|--|---|---|
| ☐ Complete Medical Record | ☐ Admission Notes | ☐ Consultation Notes | ☐ Discharge Summary |
| ☐ ECG/EEG/Cardiac Reports | ☐ Emergency Reports | ☐ History & Physical | ☐ Laboratory Reports |
| ☐ Operative Notes | ☐ Pathology Reports | ☐ Progress Notes | ☐ Radiology Reports |
| ☐ Other _____ | | | |

☐ I do ☐ I do not Authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/ or drug abuse.

Release information to

Name of Company/Agency/Facility/Person

Street Address City, State, Zip Fax#

Purpose of Disclosure:

- | | | | | |
|--|---|---|--------------------------------------|--|
| ☐ Change of Physician | ☐ Continuing Care | ☐ Disability Determination | ☐ Insurance | ☐ Legal Investigation |
| ☐ Personal | ☐ Referral to Specialist | ☐ Workers' Comp | ☐ Other _____ | |

I hereby authorize disclosure of health information for the above named patient. This Authorization is valid for **12** months from the date of signature. I understand that I may cancel this Authorization with written notice, but that it will not affect any information released prior to the notification of cancellation or released where permitted under TPMG's Notice of Privacy Practices. I understand that the information used or disclosed may be subject to re-disclosure by the third party receiving it, and it would then no longer be protected by Subpart E of the HIPAA Privacy Rules. Signing this Authorization is not a condition for treatment, payment, enrollment or eligibility for benefits.

Signature of Individual or Guardian or Personal Representative of Patient's Estate Date

There is a charge to you for a personal copy or the permanent transfer of your records to entities that are not divisions of TIDEWATER PHYSICIANS MULTISPECIALTY GROUP (TPMG). **TPMG will invoice the patient directly for a \$10.00 processing fee plus \$.50/page for the first 50 pages of the medical record, and \$.25/page over 50 pages. I have read and understand the statement above and agree to make payment for the cost of copying my medical record.**

Signature of Individual or Guardian or Personal Representative of Patient's Estate Date

For Office Use Only: ID Verified: _____ Date Records Were Sent: _____ Sent by: _____