Speer Primary Care
445A Carlisle Drive Herndon VA 20170
Ph: 703-794-3741 F: 888-873-0027

Authorization for Release of Confidential Health Records

Print Patient Full Name _____ Date of Birth _____ Phone Number _____

Address _____ City/State/Zip _____

INFORMATION RELEASE FROM:

Practice/Practitioner _____ Phone Number _____ Fax Number _____

RELEASE TO: Speer Primary Care 445A Carlisle Drive Herndon VA 20170
Phone: 703-794-3741 Fax: 888-873-0027 Email: info@speerprimarycare.com

At the request of the individual, I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months form the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of on whether or not I sign this authorization.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing or AIDS information. _____ (initial)

Signature of individual or guardian or Personal Representative of patient's estate _____ Date _____

**** I agree to pay all fees associated with this release, based on the standard fees outlined below. I understand that all above sections of this form must be completed before it can be processed. ****

*** Virginia's Health Records Privacy statute [§ 32.1-127.1:03 (J)] states "If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information [and] postage when the individual requests that such information be mailed."*

FOR OFFICE USE ONLY

RECORDS REQUESTED:

Complete Record	☐	**Imaging Reports**	☐	**Consults/Specialist Records**	☐
Progress Notes	☐	**Lab Reports**	☐	**History & Physical**	☐
Vaccine Record	☐	**Prior Physician Records**	☐		