FAIRFAX FAMILY PRACTICE CENTERS

*All items with an asterisk are **MANDATORY** fields.

A. * Patient Name _____ Medical Record Number _____
* Patient Date of Birth _____ *Contact Phone Number _____
Contact Email _____
* Patient Address _____
Street Address City State Zip Code

B. * I authorize FFPC to (check one):
❒Release the information indicated to: _____
❒Request the information indicated from: Name of person or entity to receive or disclose information

_____
Street Address City State Zip Code

Phone # _____ Fax # _____ Email _____

C. * Information to be Released/Disclosed:

Facility: _____
❒All FFPC locations
Dates of Service:
_____
_____
_____

(check all that apply):

❒Billing information
❒Complete medical record
❒Consultations
❒EKG/EEGs
❒History & Physical
❒Laboratory reports
❒Medication list
❒Physician orders
❒Progress Notes
❒Other (specify): _____

D. * Purpose (check all that apply):
❒Medical follow-up
❒Attorney
❒Personal use
❒Disability
❒Insurance
❒Other _____

E. * Provide Record by Means of (check one):
❒MyChart
❒Fax (25 pages or less)
❒Electronic media (CD/Thumb drive)
❒Mail – Regular
❒Email – Encrypted
❒Email – Unencrypted
❒Pick-up
❒Mail – Expedited. On request, FFPC can expedite record delivery. You will be billed for actual charges incurred.
❒In-Person Review. You will need to make an appointment for the review.

F. I understand that:

- If the person or agency that receives my information is not a healthcare provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
- Written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
- This disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.
- Treatment will still be provided to me, if I do not sign this form.
- This authorization will expire six (6) months after the date signed.

_____
*Patient or Authorized Representative Signature

_____
*Patient or Authorized Representative Printed Name

_____
*Date (Authorization will expire six months after date signed)

_____ ❒Self
*Relationship to Patient (specify, or check box if "self")

Interpreter Information (To be completed by FFPC staff, if applicable):
❒In person ❒Telephonic ❒Video Interpreter name/ID number (if applicable) _____

□Patient/Designated Decision Maker was offered and refused interpreter □Waiver signed