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Stafford, VA 22554

Authorization to Release Healthcare Information

Patient's Name (Last, First): _____

DOB: _____ Phone #: _____

Are your medical records filed under another name? _____

INFORMATION TO BE RELEASED **BY**:	INFORMATION TO BE RELEASED **TO**:
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone# Fax#	_____ Phone# Fax#

This request and authorization applies to (circle all those that apply):

- Complete Chart (includes all below)
- History and Physical
- Lab Reports
- Radiology Reports
- Hospital Reports
- Progress Notes
- Immunization Records
- HIV Records
- Psychiatric Records
- Drug & Alcohol Records
- Other (please specify): _____

VA law allows for a $10 administration fee PLUS $0.50/page for the first 50 pages and $0.25/page thereafter. There may be a charge for copies of your medical record unless your copies are being sent to another physician or health facility.

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Optimum Care LLC from, and covenant not to sue Optimum Care LLC, for any claim that I have or may have in the future for release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may request to inspect or copy information disclosed under this authorization. I understand that I may revoke this consent to release information at any time except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____