220 EXECUTIVE CENTER PARKWAY
FREDERICKSBURG, VA 22401
(540) 899-2900 • FAX (540) 372-6928

NEUROLOGY ASSOCIATES of Fredericksburg

PLEASE PRINT ALL INFORMATION

Date: _____/_____/_____ Chart #:_____

Patient Name: _____

Patient's Date of Birth: _____/_____/_____ Patient's SSN:_____

( ) authorize Neurology Associates of Fredericksburg to release the information specified below, in accordance with the Commonwealth of Virginia, and Neurology Associates of Fredericksburg policies to the party identified below.
( ) authorize the party identified below to release the specified information to Neurology Associates of Fredericksburg.
****VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.**

Release of Information to Person/Organization as noted below:

Patient's Name/Facility_____
Street Address_____
City, State, Zip Code_____

For the purpose of:

- Patient use
- Attorney
- Insurance (including compensation or disability)
- Information to be released to another physician **(no charge)**
- Information to be obtained by Neurology Associates of Fredericksburg **(no charge)**

Information to be Released/Obtained

Physician's Progress Notes	_____	Radiology Report	_____
Final Discharge Summary	_____	Consultation	_____
Emergency Room Reports	_____	Complete Chart*	_____
History and Physical	_____	Psychiatric Records	_____
Other (please specify)	_____		

Complete chart request does not include psychiatric, drug and alcohol, or HIV records unless specifically requested on this form.

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 so release Neurology Associates of Fredericksburg for any claim I have or may in the future release of this information. I understand that I may refuse to sign this inspect or copy information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by Federal privacy regulation, the information described above may be redisclosed and no longer protected by those regulations. I further 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 revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as: _____

Patient Signature: _____ Date: _____/_____/_____

Patient/Guardian/Patient Designee Signature: _____ Date: _____/_____/_____

Authority of Individual Signing for Patient:_____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____