☐ I authorize the Mary Washington Medical Group to release the information from the record of:
☐ I authorize the Mary Washington Medical Group to obtain records from:

Provider or Facility Name:_____

Patient Name:_____ Social Security Number:_____
Date of Birth:_____ Daytime Phone Number:_____

Address:_____

Documentation can be released electronically if stored in an electronic media.

Preferred media: ☐ Paper ☐ CD ☐ Online Record eDelivery email address:_____

Dates of Service:_____to _____

Information to be released:

☐ Labs ☐ Pathology Reports ☐ Immunization Record ☐ Progress Notes ☐ Office Visit Notes
☐ X-Rays or Imaging Reports ☐ Images ☐ Complete Medical Record ☐ Other:_____

Person/Facility to receive information:_____

Street_____City:_____State: _____ Zip Code: _____

This information is being disclosed for the following purpose:_____

Authorization to Release Information:

_____

1. I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse unless otherwise specified below in Special Instructions;

   Special Instructions, if any:_____
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
3. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as: _____(if none specified, this authorization will expire 6 months after the date specified below).
4. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied.

Signature of Patient or Legal Representative:_____Date:_____

☐ Parent or Legal Guardian ☐ Medical Power of Attorney ☐ Next of Kin Deceased ☐ Executor of Estate

Mail completed form to: Health Information Management Department
2300 Fall Hill Ave Suite 101
Fredericksburg, VA 22401

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Department Use Only

MRN_____ **ID Verified (Type and ID#)**_____

Processed By:_____**Date Processed:**_____**Pages Provided:**_____

Mary Washington Healthcare

Mary Washington Medical Group
Authorization to Release Confidential Medical Information

Rev. 3/2023