



**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

**Patient Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Authorization for Use/Disclosure of Information:** By signing this form, I \_\_\_\_\_, DOB, \_\_\_\_\_, authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below, for the last \_\_\_\_\_ years.

**To:**

Name: **VitalCare Family Practice**  
Address: **7300 Ashlake Parkway, Suite 200**  
City, State, Zip: **Chesterfield, VA 23832-2827**  
Phone: **(804) 256-8282** Fax: **(804) 256-8288**

**From:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose:** I authorize the release of my health information for the following specific purpose: \_\_\_\_\_

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

**Information to be disclosed:** I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, HIV or AIDS, drug treatment and/or abuse, mental or physical condition and any treatment received by me.
- Only the following records or types of health information: \_\_\_\_\_

**This authorization will remain in effect until I revoke it in writing.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If Individual is unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
Name of Guardian/ Representative      Legal Relationship      Date