AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

___________________________________ ________________
Print Patient's Full Name Date of Birth

___________________________________ _________________
Street Address Contact Phone Number

____
City/State/Zip Code

Information to be released:

__Visit Notes __Pathology Reports __Other_______________
__Progress Notes __Laboratory Reports

___I do/___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Date range to be released: ________________________________

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: _______________________________
Name
____
Address
____
Fax Number
____
Phone number
____
Email

PLEASE RELEASE INFORMATION TO:

Dr. Rebecca Fox
FoxCare Integrative Health
Phone: (434) 290-1210
Fax: (434) 282-2552

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I under that the information used or disclosed may be subject to re-discloser by the persons or facility receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

____ _____________________
Signature of Individual, Guardian, or Legal Representative Date