

Authorization for Release Confidential Medical Information

I, _____ authorize the following office:

Patient's Name/or Parent/Guardian

Name: _____
Organization: _____
Street Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

To release indicated Medical Information to the following Physician:

PL Physicians, Inc. – Family Practice
Molly M. Castille, MD
282 Choptank Road, Suite 103
Stafford, VA 22556
Phone: 540-318-6464
Fax: 540-628-0179

Patient Name: _____ DOB: _____

Information to be Released/Obtained:

___ Complete Chart
___ Immunization Records
___ Physician Progress Note
___ Final Discharge Summary
___ Emergency Room Reports
___ Psychiatric Records*
___ Other (please specify) _____

___ Radiology Report
___ Consultation
___ History & Physical
___ Laboratory Results
___ HIV Records*
___ Drug & Alcohol Records*

Complete chart requests DO NOT include psychiatric, drug & alcohol or HIV records unless specifically requested on the form

VA law allows for copy charges consisting of the following: \$10.00 administrative fee PLUS \$.50 per page for the first 50 pages and \$.25 per page thereafter, and \$1.00 per page of microfilm/fiche.
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 PL Physicians, Inc. from, and covenant not to sue PL Physicians, Inc. 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 used disclosed under this authorization. I understand that I may revoke this consent to release information at anytime 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, or on the date, event, or condition described as:

Patient Signature: _____ **Date:** _____
Responsible Party: _____ **Date:** _____
(If Minor)
Witness Signature: _____ **Date:** _____