<u>Authorization for Release Confidential Medical Information</u>

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
Jayalakshmi Nair, MD, AAFP
4552 Empire Court
Fredericksburg, VA 22408
Phone: 540-604-9894
Fax: 540-604-9895

Patient Name: ____ DOB:____________

<u>Information to be Released/Obtained:</u>

___ Complete Chart
___ Immunization Records
___ Physician Progress Note
___ Final Discharge Summary
___ Emergency Room Reports
___ Psychiatric Records*
___ Radiology Report
___ Consultation
___ History & Physical
___Laboratory Results
___ HIV Records*
___ Drug & Alcohol Records*
___ Other (please specify)____

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 adminstrative 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:

<u>Patient Signature:</u> ______________________________________ Date: ______________

<u>Responsible Party:</u> ______________________________________ Date: ______________
(If Minor)

<u>Witness Signature:</u> ______________________________________ Date: ______________