Account Number:_____

3198 Pacific Avenue Suite 104
Virginia Beach, Virginia 23451
Phone: 757-428-1911 | Fax 757-470-5977

AUTHORIZATION TO RELEASE/ RECEIVE MEDICAL INFORMATION

I, the undersigned, authorize **THE DOCTOR'S IN, 3198 Pacific Avenue Suite 104, Virginia Beach, Virginia 23451** to **RELEASE OR RECEIVE (CIRCLE ONE)** my health information as noted below:

Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____
Zip:_____ State:_____ Phone Number: _____

Release/ Receive Information To: (please note all fields must be complete in order to fulfill request)

Name/Facility: _____ Phone Number:_____
Fax Number:_____ Type of Practice:_____

Name/Facility: _____ Phone Number:_____
Fax Number:_____ Type of Practice:_____

Name/Facility: _____ Phone Number:_____
Fax Number:_____ Type of Practice:_____

Information to be Released/Received:

(Please check one) ☐ Date(s) of Service: _____ ☐ Entire Medical Record

☐ Specific Information:_____

Purpose of Request: ☐ Personal Records ☐ Second opinion OR transfer to another physician

I understand that my medical record or personal health information may contain information regarding alcohol or substance abuse, HIV/AIDS, or mental health records and that these records may be disclosed to the above facility.

This authorization will expire 1 year from the date below. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.

Patient Signature:_____ **Date**: _____

Signature of Parent of Legal Guardian:_____**Date**:_____
(required for all patients under the age of 18)