MOUNTAIN VIEW MEDICAL ASSOCIATES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________________	__________________________
Print Patients full name	Date of Birth
______________________________________	__________________________
Street Address	Social Security Number
______________________________________	__________________________
City/State/Zip Code	Home phone number

_______Discharge Summary	_______Pathology Reports	_______Emergency Reports
_______History & Physical	_______Laboratory Reports	_______Other
_______Progress Notes	_______Radiology 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.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: ___________________________________
____
____
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PLEASE RELEASE INFORMATION TO: MOUNTAIN VIEW MEDICAL ASSOCIATES
205 East Hirst Road, Suite 203
Purcellville, Virginia 20132
540-751-0255/FAX-540-751-0466

PURPOSE OF DISCLOSURE:

____Referral to Specialist	____Insurance	____Workers Comp	____Change of Doctor/Provider
____Legal Investigation	____Personal	____Continuing Care	____Disability Determination

____Other (please specify)____

Please provide the best telephone number in the event we need to contact you (home, work or cell)
(_________)__________-__________.

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 understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then 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 or not I sign the authorization.

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