MEDICAL RECORD RELEASE AUTHORIZATION

I authorize:

Alesia W. Griffin, M.D., P.C.,
1413 Kempsville Road.
Chesapeake, VA 23320
(757)366-0692 *FAX:* (757)366-9118

to: ☐ receive records from (including drug and/or alcohol records; HIV testing results

☐ release records to (including drug and/or alcohol records; HIV testing results)

_____
Name of Physician/Facility

_____
Address

_____
City/State/Zip

Phone:_____ Fax:_____

Purpose of the use or disclosure:

☐ Permanently changing doctors

☐ Other, please specify_____

Information to be provided: **Date(s) of Treatment_____**

☐ Send complete medical record
☐ History and Physical
☐ Progress Notes
☐ Other (Specify) _____
☐ Laboratory Reports
☐ Pathology Reports
☐ Shot Record
☐ Medications
☐ Consultations
☐ X-ray Report

This authorization shall remain valid for 90 days. *I understand that I may revoke this consent at any time but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without separate written consent unless such recipient is a provider who makes a disclosure permitted by law.*

Patient Name _____ *Legal Guardian _____
(Please print) (Please print)

Patient DOB _____

Address _____City/State Zip Code_____

Signature _____ Date_____
Patient/*Legal Guardian

Witness_____ Date_____

*Required if Patient under 18 years of age.

PLEASE NOTE THAT FEES MAY APPLY FOR RECORD PROCESSING. MEDICAL RECORD PROCESSING MAY TAKE UP TO 10 - 14 BUSINESS DAYS.