AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Birth Date: ____/_____/_____

Street Name: _____ Social Security Number: _____

City, State, Zip: _____ Phone: _____

At the request of the individual, I _____, do hereby authorize **Mansilla Medical Practice** to release or obtain the following:

____Discharge Summary	____ Pathology Reports	___ Progress Notes
____Emergency Reports	____ Radiology Reports	____Operative Notes
____Laboratory Reports	____ EEG/BCG/Cardiac Cath	____Other: _____

Service Dates: _____

____ **I do**/_____ **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.

____To ____From:

Mansilla Medical Practice

360 Brown's Hill Court

Midlothian, VA 23114

Phone: 804-379-3100

Fax: 804-379-3200

____To ____From:

_____

_____

_____

_____

_____

I hereby authorize disclosure of the health information for the above-named patient. This 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 is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature: _____ Date: _____