Fredericksburg Christian Health Center
1129 Heatherstone Drive
Fredericksburg, Va 22407
Phone 540-785-8500 Fax 540-785-5328

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

PATIENT'S NAME (PLEASE PRINT): _____

PATIENT'S ADDRESS: _____ **DATE OF BIRTH:** _____

_____ **HOME PHONE #:** _____

I REQUEST THAT MY MEDICAL RECORDS BE TRANSFERRED FROM:

DOCTOR OR FACILITY NAME: _____

ADDRESS: _____ **PHONE #:** _____

_____ **FAX #:** _____

TO:

DOCTOR OR FACILITY NAME: _____

ADDRESS: _____ **PHONE #:** _____

_____ **FAX #:** _____

EXTENT OF INFORMATION TO BE RELEASED: ____ COMPLETE CHART ____LABS ____ XRAYS ____ OTHER
DATES OF SERVICE: _____

_____ I DO _____ I DO NOT AUTHORIZE THE RELEASE OF INFORMATION RELATED TO AIDS OR HIV IINFECTION, PSYCHIATRIC CARE AND/OR PSYCHOLOGICAL ASSESSMENT, AND TREATMENT FOR ALCHOL AND/OR DRUG ABUSE.

I understand that the copying fee for records provided by Fredericksburg Christian Health Center is as follows: $0.50 per page for the first 50 pages and then $0.25 per page for each additional page copied for personal use. Payment for the records must be paid in full before the patient receives the records.

I understand that I have the right to access my medical records in accordance with the law and policies of Fredericksburg Christian Health Center. I understand that Fredericksburg Christian Health Center charges me for copies of my medical records for personal use. And I acknowledge of the fee schedule listed above.

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 will not effect 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/s or facility receiving it and would then no longer be protected by federal regulation. I understand that the medical provider to whom this is furnished may not condition treatment of me on whether or not I sign this authorization.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

PLEASE MAIL RECORDS TO THE OFFICE ADDRESS ABOVE—ONLY FAX RECORDS LESS THAN 15 PAGES

Date Received _____ **Date Mailed/Faxed** _____