VIRGINIA GATEWAY URGENT CARE CENTER

7516 Iron Bar Lane
Gainesville, VA 20155
P: 703-754-9111
F: 703-754-1211

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____ **DATE**: _____

PATIENT DATE OF BIRTH: _____ **PATIENT SOCIAL**: _____

Complete the following only if the person authorizing is not the patient.

AUTHORIZING AGENT NAME: _____ RELATIONSHIP TO PATIENT:_____

I hereby authorize that **Virginia Gateway Urgent Care Center**:

RELEASE / OBTAIN

(Circle one)

the protected health information regarding the above named person to/from:

Person/Institution_____
Address_____**City**_____**State**_____**Zip**_____
Phone_____**Fax**_____

Records requested: ☐ Offices Notes ☐ Labs ☐ Pharmacy/Medication ☐ Other_____

This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:
Reason for Disclosure (Circle One):
Patient Request; ☐ Workers' Compensation; ☐ Treatment; ☐ Insurance; ☐ Disability; ☐ Legal; ☐ Other

- I understand that, by federal law, Virginia Gateway Urgent Care Center may not use or disclose protected health information without authorization except as provided in Virginia Gateway Urgent Care Center Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above. I hereby release, indemnify and hold harmless Virginia Gateway Urgent Care Center, its officers, directors, employees, agents and members of its medical staff from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws and could be re-disclosed by the person or agency that receives it.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address to the institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form to assure treatment.
- I authorize that this information may be faxed to the requesting Health Care Provider.
- I further agree to pay the fees as listed to provide the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider.

This authorization expires automatically one (1) year from the date signed if no other date listed here: _____

Signed_____ Witness_____

Please allow 5-7 business days to complete this request. We cannot release hospital records or records from other physicians. All records requested are subject to a processing fee; however, records can be faxed to another physician's office free of charge.