Mount Vernon Internal Medicine
Authorization for Release of Medical Records

MT. VERNON INTERNAL MEDICINE

Patient Name: _____ Date of Birth: _____

Phone: _____Cell: _____Work: _____

Email:_____Address: _____

City: _____State: _____Zip: _____

INFORMATION TO BE RELEASED ***BY***:

☐ Mount Vernon Internal Medicine

☐ Other Organization:

Name:_____
Address:_____
City:_____Zip:_____State:_____
Phone:_____Fax:_____

INFORMATION TO BE RELEASED ***TO***:

☐ Mount Vernon Internal Medicine

☐ Other Organization:

Name:_____
Address:_____
City:_____Zip:_____State:_____
Phone:_____Fax:_____

At the request of the individual I, _____, do hereby authorize Mount Vernon Internal Medicine or other organization to release:

☐ Office Visits (last 2 years only) ☐ Immunization record ☐ Lab results/X-ray reports
☐ Consultation reports ☐ Procedures/Surgeries ☐ Other (Please Specify) _____

___I do___I do NOT authorize release of information related to AIDS or HIV Infections, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug use.

FOR THE FOLLOWING DATE(S): From: _____/_____/_____ To: _____/_____/_____ ■ ALL RECORDS
Day /Month/Year Day/Month/Year

*****Mount Vernon Internal Medicine is working in conjunction with HealthPort Company. HealthPort will contact you regarding fees for any medical record released to you or your designated person of contact. *****

Please Note: When requesting records to be sent from MVIM, it is standard that MVIM will only send the last two years of records. Also note, MVIM will send records to include anything that was done by MVIM and not outside providers or facilities. You must request those records from that individual provider or facility.

For the purpose of: *(Please Specify)*_____

_____

All fees are established & compliant in accordance with Virginia Law Title 32.1 Health and Virginia General Assembly code 8.01-413 governing the release of health information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing & present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in **12 months** from the date of my signature below. A photocopy of this authorization is as valid as the original date, event, or condition.

I understand that Mount Vernon Internal Medicine may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable & are set forth in this authorization.

I understand that authorizing the disclosure & release of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in **CFR 164.524**. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have further questions about disclosure of my health information I may contact Mount Vernon Internal Medicine's Privacy Officer.

_____ _____
Patient Signature or legal representative Date

_____ _____
Signature of witness Date

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state & federal law. No further disclosure of this information should be done without specific, written & informed release of the individual to whom it pertains or as permitted by state & federal law.

Mount Vernon Internal Medicine-Admin.
7764 Armistead Road Suite 240 Lorton, Virginia 22079
Phone: 703.780.2800 Fax: 703.780.0461
mtvernoninternalmedicine.com