MOUNTAIN VIEW MEDICAL ASSOCIATES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| ______________________________ | ______________________ |
|---|---|
| Print Patients full name | Date of Birth |
| ______________________________ | ______________________ |
| Street Address | Social Security Number |
| ______________________________ | ______________________ |
| City/State/Zip Code | Home phone number |

| | | |
|---|---|---|
| ______Discharge Summary | ______Pathology Reports | ______Emergency Reports |
| ______History & Physical | ______Laboratory Reports | ______Other |
| ______Progress Notes | ______Radiology Reports | ____________________ |

______I do ______I 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.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: ______________________________
______________________________
______________________________
______________________________

PLEASE RELEASE INFORMATION TO: MOUNTAIN VIEW MEDICAL ASSOCIATES
205 East Hirst Road, Suite 203
Purcellville, Virginia 20132
540-751-0255/FAX-540-751-0466

PURPOSE OF DISCLOSURE:

| | | | |
|---|---|---|---|
| ____Referral to Specialist | ____Insurance | ____Workers Comp | ____Change of Doctor/Provider |
| ____Legal Investigation | ____Personal | ____Continuing Care | ____Disability Determination |

____Other (please specify)________________________________________________

**Please provide the best telephone number in the event we need to contact you (home, work or cell)**
**(________)_________-_________.**

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 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 authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________________ **Date**____________________
**Signature of Individual, Guardian or Legal Representative**