MINOR EMERGENCY
AND
FAMILY CARE CENTER, INC.

1368 North Great Neck Rd.
Virginia Beach, VA 23454
757-412-0006

REQUEST FOR AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR HEALTH INFORMATION

Patient Name:_____ **D.O.B**.:_____

Persons/Organization providing the information:

_____

_____

_____

Persons/Organization receiving information:

Minor Emergency and Family Care Center Inc.

1368 N. Great Neck Road Virginia Beach, VA 23454

(P) 757-412-0006 (F)757-496-2069

Specific description of information including date(s):

_____
_____
_____
_____

The information described above will be used or disclosed for the following purpose(s):

_____
_____
_____
_____

Expiration Date:
This authorization will expire:_____days OR other:_____ from signed date.
To be completed by the patient or personal representative:
I hereby authorized the use or disclosure of my protected health information as described above.
I understand that this authorization is voluntary and that the ability to obtain treatment will not be affected if I do not sign this form unless that treatment is for a fitness-for-duty evaluation or a research related treatment.
I understand that is the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.
I understand that I have a right to revoke this authorization by sending written notification to: The Facility Privacy Officer at the above address. Any revocation will not affect disclosers made prior to Minor Emergency and Family Care Center, Inc.'s receipt or knowledge of the revocation.
I understand that I have a right to inspect and receive a copy of the information described in this form.
I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient/Patient Representative **Date**

_____ _____
Printed Name of Patient/Patient Representative **Relationship**