

**REQUEST TO RELEASE
CONFIDENTIAL MEDICAL INFORMATION**

TO: _____
Name _____

Address _____ Phone/FAX _____

I-Patient/Parent/Guardian _____ DOB ___/___/___ SSN _____

Authorize the release the information specified below to:

**Rappahannock Neurology Specialists
1101 Sam Perry Blvd, Suite 414
Fredericksburg, VA 22401
Phone (540) 899-1354 FAX (540)899-1359**

INFORMATION TO BE RELEASED

Physician's Progress Notes	_____	Radiology Report	_____
Final Discharge Summary	_____	Consultation	_____
Emergency Room Report	_____	Complete Chart	_____
History and Physical	_____	Psychiatric Records	_____
Laboratory Results	_____	Drug and Alcohol Records	_____
Other (specify) _____			
Date(s) of Service: _____		Medical Record Number: _____	

The purpose(s) for the disclosure of the above information is:

_____ Continuing Care
_____ Other: _____

I hereby voluntarily authorize, allow, and cause the release of information indicated above. No threat of other coercive measures have induced me to sign this consent form, and I do hereby release MediCorp Health System from all legal liability that may arise from the release of the information requested.

This information may be disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this document will be null and void 6 months after the date of this document, or on the date, event or condition specifically described as: _____

_____ Patient Signature	_____ Date	_____ Witness Signature	_____ Date
_____ Parent/Guardian Signature	_____ Date		