INOVA LOUDOUN AMBULATORY SURGERY CENTER, LLC.

Medical Records Release Authorization for use or disclosure of protected health information.

Patient Name _____
Date of Birth _____ Medical Record #_____
Daytime Phone #_____Evening Phone #_____
Address _____City_____State_____Zip Code_____

I hearby authorize Inova Loudoun Ambulatory Surgery Center to use or disclose my protected health information as indicated below to:

Name_____Phone #_____Fax #_____
Address_____City_____State_____Zip Code_____

Information to be released:
From & To Dates:_____

- ☐ History & physical exam
- ☐ Lab report
- ☐ X-ray report
- ☐ Consultation report
- ☐ Other

Purpose of Disclosure:

☐ Changing Physicians ☐ Second Opinion
☐ Continuing Care ☐ Legal
☐ At my (patient) request ☐ Insurance
☐ Workers' Compensation ☐ School
☐ Other_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

☐ Substance Abuse (including alcohol/drug abuse
☐ Mental Health
☐ Psychotherapy Notes
☐ HIV related information (including AIDS related testing

The confidentiality of this record is required under Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

_____ _____
Signature of patient or legal guardian date

1. I understand that this authorization will expire six months from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. **Inova Loudoun Ambulatory Surgery Center, 44035 Riverside Parkway #200, Leesburg, VA 20176**
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign the authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____
Print Name of Patient or Authorized Representative Relationship to Patient

_____ _____
Signature of Patient or Authorized Representative Date/Time (Authorization will expire six months after date signed)

Records Received By _____ Date/Time_____