At Home Harmony

Authorization to Release Medical Records

Request to: At Home Harmony
1504 Santa Rosa Rd Room 114 Henrico VA 23229
Phone: 804-210-3103 Fax: 804-288-1538

Patient Name: (please print)			
DOB:		**Date(s) of Service:**	

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

- ☒ Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Military
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability
- ☐ Other:

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ Allergy List
- ☐ Consult Orders
- ☐ Demographics/Face Sheet
- ☐ Encounters/Provider Visits
- ☐ Lab Orders/Results
- ☐ Medication List
- ☐ Prescription Documents
- ☐ Vaccination History/ Records
- ☐ Other:

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released):

SEND RECORDS TO:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)	Phone Number
◉ Send to: Address (Street, City, State and ZIP)	○ Send via fax, Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) month from the date of my signature, unless I revoke the authorization prior to that time.

Signature of Patient or Legally Authorized Representative	Date Signed
Printed Name of Signatory	Relationship to Patient