

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: ____/____/____

This authorizes Carient to provide a copy, summary, or narrative of my medical records as indicated by the check mark(s) below, or otherwise release confidential information.

- Complete records
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____
- Confer with person(s) listed below orally about my medical information: _____

The reasons or purposes for this release of information are as follows:

HIV/AIDS/Mental, Health/Substance Abuse Treatment /STD's (If Applicable)

I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, including STD records, mental health treatment records, and substance abuse treatment records, along with the rest of my medical records.

Initials: _____ **Date:** _____

Release to the following person(s):

Name: _____
 Address: _____
 City: _____ State: _____
 Zip: _____
 Expiration Date: _____ or expiration event as detailed below:

• I understand that Carient will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.

- I understand that I may revoke this authorization at any time by notifying Carient in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- I understand that if the request is more than 5 pages there will be a \$25.00 fee.

Patient Signature: _____ Witness Signature: _____
 Date: _____ Date: _____