Harrisonburg Family Practice
1831 Reservoir Street, Harrisonburg, VA 22801
Phone: 540-433-9151
Fax: 540-433-0547

Authorization for Release of Information TO HFP

Patient Name: _____

Date of Birth: _____ Phone Number:

_____

I hereby authorize:
Name (*Medical Practice, Office, Provider*):

_____

Address: _____

Phone: _____Fax: _____

To release the information to:

Harrisonburg Family Practice
1831 Reservoir Street
Harrisonburg VA 22801
Phone: 540-433-9151 Fax: 540-433-0547

I hereby authorize the following information to be released: Date Range:

- ☐ Complete Chart _____
- ☐ Progress Notes / History and Physicals _____
- ☐ Lab Reports _____
- ☐ Immunizations _____
- ☐ Radiology _____
- ☐ Other (specify) _____ _____

Purpose of Sending/Receiving Records: (*Please circle one*)

Transfer of Care Communication Legal Other (Specify)_____

I specifically authorize the release of information related to Substance Abuse, Mental Health, and HIV related information: Yes No Initial:

_____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except in the event that Harrisonburg Family Practice has already acted in reliance upon this authorization. I understand that this authorization will expire one year from today's date. Any written revocation must be submitted to Harrisonburg Family Practice.

Patient's Signature (Parent/Guardian/POA):

_____

Printed Name: _____Today's Date:

_____