HARRISONBURG FAMILY PRACTICE
PATIENT AUTHORIZATION FOR PRACTICE
TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Harrisonburg Family Practice to use and or disclose certain personal health information about me to or from parties listed below, information faxed must be under 50 pages otherwise needs mailed:

1. Information to be **released from**:
   Name/Agency:_____
   Address:_____
   Phone:_____Fax:_____
   Information to **release to:**
   Name/Agency:_____
   Address :_____
   Phone:_____Fax:_____
2. This authorization permits Harrisonburg Family Practice to use or disclose the Following individually identifiable health information:
   ___Complete record __Progress notes __Lab
   ___Procedures __Consultations __X-ray
   ___Immunizations __Dischargesummary __Diagnostics
   For the purpose of:
   ____Continuing of care ___Communication ___Legal presentation
   ____Other:_____
3. This authorization will expire on_____

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 to the event the HARRISONBURG FAMILY PRACTICE has acted in reliance upon this authorization. My written revocation must be submitted to HARRISONBURG FAMILY PRACTICES at
1831 Reservoir Street, Harrisonburg, VA 22801; Phone: 540-433-9151
Fax: 540-433-0547

_____ _____
Patient's Name (printed) Patient's Date of Birth

_____ _____
Patient's Social Security Number Patient's Phone Number

_____ _____
Relationship to Patient Date

_____
Signature of Patient or Legal Guardian