

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION  
AT THE REQUEST OF THE PATIENT/PATIENT REPRESENTATIVE**

At the request of \_\_\_\_\_ (patient/patient representative), this document authorizes \_\_\_\_\_ (clinic/office/physician) to disclose protected health information from the records of \_\_\_\_\_ (patient name) DOB \_\_\_\_\_ to \_\_\_\_\_ (hospital/physician/self/other) at \_\_\_\_\_

\_\_\_\_\_ I agree that any and all health information may be disclosed, including but not limited to mental health, drug or alcohol use, HIV/AIDS test results and any other records protected by state or federal laws. **OR...**

\_\_\_\_\_ I request that release of protected health information be restricted to the following portions of the medical record:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.
- I understand that I have the right to revoke this authorization, *in writing*, at any time by sending such written notification to the practice at 3025 Berkmar Drive, Charlottesville, VA 22901. (office mailing address).
- I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.
- I understand this authorization ends 12 months/1 year from the date of my signature.
- I agree to pay a reasonable cost to cover this service.

\_\_\_\_\_  
Patient/Patient Representative Signature      Date

- Patient Representative:
- Parent/Guardian of Minor Patient
- Guardian/Conservator
- Next of Kin/Executor of Deceased

\_\_\_\_\_  
Signature Witness      Date

\_\_\_\_\_ Copy given to patient/patient representative.  
\_\_\_\_\_ Original placed in medical record

**SHARING INFORMATION WITH FAMILY & FRIENDS**

To protect the confidentiality of our patients, we ask you to fill out this form. Please indicate who you will allow us to discuss your medical care. If you do not let us know who we are able to speak to, we will not discuss your medical care with them.

I \_\_\_\_\_ give my permission to Charlottesville Family Medicine, P.C., to discuss my medical care and/or leave messages with the following people:

\_\_\_\_\_  
Name relationship

\_\_\_\_\_  
Name relationship

\_\_\_\_\_  
Name relationship

\_\_\_\_\_  
Name relationship

\_\_\_\_\_  
Name relationship

\_\_\_\_\_  
Signature date