Medical Record Release of Information Authorization

Who

Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.

Patient Name:________________________________ **Date of Birth:** _____ / _____ / _________ **SSN #: (last 4)** __________________

AKA or Maiden Names: ____

Patient Address: ____

City: ____**State:** _____ **Zip Code:** _____________ **Phone:** ______________________

Email: ____ **Fax:** ________________________

Where

Doctor you would like information from

Doctor or Facility Name: Crossroads Medical Mission

Address: 433 Scott St

City: Bristol **State:** VA

Zip Code: 24201 **Fax:** (276) 466 - 2800

Where you would like information sent

Please indicate all fields even if you would like the records faxed. Larger files cannot be faxed and RRS will need a complete mailing address

☐ **Self**

Doctor or Facility Name:____________________________________

Address: ____

City: _____________________________________**State:** _________

Zip Code: ___________ **Fax:** ________________________________

What

In order to receive the fastest service, please specify the information being requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows RRS to provide the quickest turnaround times.

Dates of Service: - From: _____/_____ / _______ **To:** _____/_____ /________

Specific Information: ____

Records will be delivered VIA ELECTRONIC DELIVERY unless otherwise indicated. **Deliver on Paper:** _______ **Yes**

Why

Purpose of Disclosure - Please select one:

☐ **Referral to Specialist** ☐ **Insurance** ☐ **Workman's Comp**
☐ **Legal Investigation** ☐ **Disability Determination/Claim** ☐ **Personal**
☐ **Transfer of Care** ☐ **2nd Opinion** ☐ **Other:**

Legal Requirements

You MUST agree or disagree to each of the following. Please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date ____/_____/_________

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated.

Agree ______ Disagree _____ N/A _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Agree ______ Disagree _____ N/A _____ Psychiatric care and/or psychological assessment
Agree ______ Disagree _____ N/A _____ Treatment for alcohol and/or drug abuse.
Agree ______ Disagree _____ N/A _____ Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

Signature

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above-named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent/guardian signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.

____ Date: ________________

Signature of Patient or Authorized Representative