Vienna Family Medicine
115 Park Street SE, Suite 300 Vienna, VA 22180 (703) 255-9100

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please note: An invoice for payment from HealthPort will be sent to you for your records.
Please contact HealthPort Customer Service at (800) 367-1500 with any questions.

_____ Print patient's full name

_____ DOB (MM/DD/YY)

_____ Street Address

_____ Primary Phone Number – Home/Mobile/Work

_____ City, State, Zip Code

_____ Secondary Phone Number – Home/Mobile/Work

At the request of the individual, I _____, do hereby authorize Fairfax Family Practice Centers to release:
Patient's Name

Dates of _____

HEALTHPORT:
___Discharge Summary ___ History & Physical ___ Pathology Reports ___ **ALL RECORDS**
___ ECG/EEG/Cardiac Cath ___ Operative Notes ___ Progress Notes
___ Emergency Reports ___ Laboratory Reports ___ Radiology Reports

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infections, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug use.

Withhold Specific Dates of: _____

INFORMATION RELEASE TO:

____ **CHECK HERE for HEALTHPORT e-Delivery**

____ **Additional Form required**

_____ Name of Company/Agent/Facility/Person

_____ Street Address

_____ City, State, Zip Code

PURPOSE OF DISCLOSURE:

___ Referral to Specialist ___ Insurance ___ Personal ___ Leaving Practice
___ Legal Investigation ___ Workers Comp ___ Continuing Care ___ Disability Determination

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to who this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ Signature of individual or guardian (if person is under 18 years of age) or personal representative of patient's estate

_____ Date

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will bill you directly. VA State rates apply. Pages 1-50 $ 0.50/page. Pages 51+ are $0.25 each plus the cost of first class postage.

HealthPort

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requestor Name		
	First	**Last**
Street Address		
	Street	**Suite / Apt #**
	City	**State / Zip Code**

Email Address for Record Delivery

Medical Records Requested			
Patient Name			
	First	**MI**	**Last**
Date of Birth			
Date of Service			
	From	**To**	

Please provide me with the medical records described above through the HealthPort eDelivery online service.

I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- **There will be a fee for collecting my records. If so, an invoice will be included with the records.**

Signature _____ Date _____