TPMG
YOUR HEALTH, SKILLFULLY GUIDED

Authorization to Release Medical Information

Please Print Clearly

Patient's Full Name _____ Account# _____

Date of Birth (Month/Day/Year) _____ Last four of Social Security # _____ Phone _____

Street Address _____ City, State, Zip _____

I, _____
Patient's Name

Do hereby authorize _____ **to release:**

- ☐ Complete Medical Record
- ☐ Admission Notes
- ☐ Consultation Notes
- ☐ Discharge Summary
- ☐ ECG/EEG/Cardiac
- ☐ Emergency Reports
- ☐ History & Physical
- ☐ Laboratory Reports
- ☐ Reports Operative Notes
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Clinical Research
- ☐ Other _____

This authorization for release of medical information covers the period of healthcare from _____ to _____

☐ **I do** ☐ **I do not** Authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/ or drug abuse.

Release information to _____
Name of Company/Agency/Facility/Person

Street Address _____ City, State, Zip _____ Fax# _____

Purpose of Disclosure:

- ☐ Change of Physician
- ☐ Continuing Care
- ☐ Disability Determination
- ☐ Insurance
- ☐ Legal Investigation
- ☐ Personal
- ☐ Referral to Specialist
- ☐ Workers' Comp
- ☐ Other _____

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 Authorization with written notice, but that it will not affect any information released prior to the notification of cancellation or released where permitted under TPMG's Notice of Privacy Practices. I understand that the information used or disclosed may be subject to re-disclosure by the third party receiving it, and it would then no longer be protected by Subpart E of the HIPAA Privacy Rules. Signing this Authorization is not a condition for treatment, payment, enrollment or eligibility for benefits.

Signature of Individual or Guardian or Personal Representative of Patient's Estate _____ Date _____

There is a charge to you for a personal copy or the permanent transfer of your records to entities that are not divisions of Tidewater Physicians Multispecialty Group (TPMG). **TPMG will invoice the patient directly for a $10.00 processing fee plus $.10/page. I have read and understand the statement above and agree to make payment for the cost of copying my medical record.**

Signature of Individual or Guardian or Personal Representative of Patient's Estate _____ Date _____

For Office Use Only: **ID Verified:** _____ **Date Records Were Sent:** _____ **Sent by:** _____