

**Martha Jefferson Medical Group**  
**AUTHORIZATION FOR RELEASE OF INFORMATION**

I \_\_\_\_\_ authorize  
(Patient Name or Legal Guardian)

**RELEASING ENTITY:**

- Practice Name: \_\_\_\_\_  
 Martha Jefferson Medical Enterprise (CBO): \_\_\_\_\_

to release the information noted below to \_\_\_\_\_  
(Name of recipient(s))

at the following address: \_\_\_\_\_

**Physician's Phone**

**Physician's Fax**

- Abstract (Last 3 Office Notes, Last EKG)  
 Laboratory Report (In office labs only)  
 Pathology Report  
 Consultation Report  
 PAP Report

- Medication Records  
 Billing & Payment History  
 History and Physical Exam  
 Radiology Report  
 Other \_\_\_\_\_

For Mammography Films, Please return signed authorization or films to: Martha Jefferson Outpatient Care Center; Attn: Mammography Film Library, 595 Peter Jefferson Parkway, Charlottesville, VA 22911

**Dates of Service:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Last 4 Digits Social Security Number :** \_\_\_\_\_

**Phone Number-Home:** (\_\_\_\_) \_\_\_\_\_ **Work:** (\_\_\_\_) \_\_\_\_\_

**Purpose of request:**  Personal use  Continuing Care  Other/state purpose \_\_\_\_\_

In the event Martha Jefferson Physician Service Group provides copies to individuals or organizations as I request, I understand that there is a fee for copying of records. Fees are waived when copies are sent to other health care providers/agencies/facilities. All other requests are charged as state and federal laws allow. As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include if applicable, **PSYCHIATRIC, SUBSTANCE ABUSE OR HIV/AIDS TESTING/TREATMENT** records and other information contained in the medical record, unless otherwise indicated under my special instructions written below. I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the releasing entity listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

**Special Instructions:** \_\_\_\_\_ (none if blank)

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

If signed by Legal representative or other than patient, indicate relationship to patient.

Picture ID and signature Verified by employee: \_\_\_\_\_

This Authorization is only valid for the information/purpose(s) indicated above, and **expires 180 days (6 months)** from signature date unless otherwise indicated on this authorization.