

**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: **Dr. Alexander Schult / Martha Jefferson Medical Associates**  
at the following address: **459 Locust Avenue, Charlottesville, VA 22902**

Physician's Phone: **(434) 654-5290**

Physician's Fax: **(434) 654-5262**

- |   |  |
|---|--|
| <input type="checkbox"/> Abstract (Last 3 Office Notes, Last EKG) | <input type="checkbox"/> Medication Records        |
| <input type="checkbox"/> Laboratory Report (In office labs only)  | <input type="checkbox"/> Billing & Payment History |
| <input type="checkbox"/> Pathology Report                         | <input type="checkbox"/> History and Physical Exam |
| <input type="checkbox"/> Consultation Report                      | <input type="checkbox"/> Radiology Report          |
| <input type="checkbox"/> PAP Report                               | <input type="checkbox"/> 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.