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OB-GYN Associates of Northern Virginia, Ltd.

MEDICAL RECORD	**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

PHYSCIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION	**It is understood that this authorization may be revoked at any time, if requested in writing, except to the action will have already been taken.**

PATIENT DATA

NAME (*Last, First, MI*)	**DATE OF BIRTH**	**SOCIAL SECURITY/IDENTIFICATION NUMBER**
PERIOD OF TREATMENT (*Month, Day, Year*)	**TYPE OF TREATMENT** ☐ All Medical Records ☐ Laboratory results Only ☐ Obstetrical Records ☐ Other: _____	

RESTRICTIONS ON INFORMATION (*Specify*)

USE OF MEDICAL INFORMATION

☐ **FURTHER MEDICAL CARE** ☐ **INSURANCE CLAIM(S)** ☐ **ATTORNEY** ☐ **DISABILITY DETERMINATION**

☐ **OTHER** (*Specify*)

INFORMATION DESTINATION

INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED (*Name and Address*)

OB-GYN Associates
Inova Franconia – Springfield Healthplex
6355 Walker Lane, Suite 408
Alexandria, VA 22310
703.719.5901 • Fax 703.719.9628

(ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE)

RELEASE AUTHORIZATION

I hereby request and authorize the name physician/medical treatment facility to release the medical information described above to the named individual/organization indicated.	**DATE**
SIGNATURE OF PATIENT/PARENT/GUARDIAN	**RELATIONSHIP**

TYPE OF IDENIFICATION