Marion Bissell, M.D.
Tina T. Pham, M.D.
Jennifer R. Santiago, M.D.
Aditi Agarwal, M.D.

OB-Gyn Associates of Northern Virginia, Ltd.

MEDICAL RECORD	**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

PHYSCIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION **OB-GYN Associates** **Inova Franconia – Springfield Healthplex** **6355 Walker Lane, Suite 408** **Alexandria, VA 22310** **703.719.5901 • Fax 703.719.9628**	**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***)

(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	

Women's Care for All Generations