LOUDOUN MEDICAL GROUP
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient:

_____ Print Patient full name

_____ Birth date (mm/dd/yyyy)

_____ Street address

_____ Social Security Number (optional)

_____ City / State / Zip

_____ Phone number

Information requesting:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes (last year)
- ☐ Operative Notes
- ☐ Pathology Reports
- ☐ Lab Reports (last 5 years)
- ☐ Radiology Reports
- ☐ ECG/ EEG/ Cardiac Cath
- ☐ Emergency Reports
- ☐ Other (specify): _____ _____

Authorize 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. _____ I do **OR** _____ I do NOT

Requesting information TO:

NAME: _____
ADDRESS: _____
_____
PHONE : _____
FAX: _____

Release information FROM:

LMG PRIMARY AND IMMEDIATE CARE CENTER
46440 BENEDICT DRIVE, SUITE 107
STERLING, VA 20164
PHONE 703-450-1125 FAX 703-450-1145

Purpose of Disclosure:

- ☐ Referral to specialist
- ☐ Legal Investigating
- ☐ Insurance
- ☐ Disability determination
- ☐ Workers Comp
- ☐ Personal
- ☐ Change of Doctor/ Provider
- ☐ Continuing care

Please provide the best telephone number in the event we need to contact you:
(_____) _____-_____

I hereby authorize disclosure of the 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 request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed by be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ Signature of Patient / Personal Representative/ Guardian

_____ Date

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