Authorization for Release of Medical Records

I hereby authorize **Abingdon Internal Medicine** to obtain/release protected health information from/to.

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Name of Doctor/Facility

______________________ ______________________

Phone Number Fax Number

This authorization permits Abingdon Internal Medicine to obtain/release the following health information.

___ Entire Record ___ Radiology Reports ___Lab Reports

___ Recent Office Visit/Notes ___ Other: ______________________

This information will be used for the continuation of medical care. I understand that I may revoke this authorization at any time by notifying in writing the Medical Record Department at Abingdon Internal Medicine, P.C. office. Such notice will not affect any actions already taken prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

______________________ ______________________

Patient Name Date of Birth

______________________ ______________________

Telephone Number Social Security (Required)

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Patients Signature (Guardian) Relationship to Patient Date

Medical Record Releases are valid ONE Year from date of signature.