Beauregard Medical Center

Ph: 703-820-7000 Fax: 703-931-0059

4660 Kenmore Avenue,
Ste 900, Alexandria, VA 22304

Authorization for Release of Medical Information

www.beauregardmedicalctr.com

Personal Information

Social Security #:_____Date of Birth: _/ _/_____Age:_____ Sex: M F

Patient's Name: Last_____First_____ Mi_____

Patient's Address:_____ Apt#:_____

City:_____State:_____ ZIP: _____

Home Telephone:_____ Work Telephone:_____Ext_____ Cell:_____

(Please check the information you are requesting)

____ Office Visit Notes ____Laboratory Reports ____ EKG/Stress/Echo/Holder
____ X-Rays Reports ____ Allergy Records ____ Immunizations
____ All Records ____ Outside Reports

I _____, do hereby authorize Beauregard Medical Center to release or get
(Patient's Name)

Please Circle on Opinion: **Release or Get Records From**

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Purpose of Disclosure:

_____ I do, _____ NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessments and treatment for alcohol and / or drug abuse

I hereby authorize disclosure of the health information above. 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 affect any information release prior to notification of cancellation, I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations.

_____ _____
Signature of Patient/Guardian/Legal Representative Today Date

****** Note: There will be a charge for personal copy and permanent transfer of your records *****