

**NOVA MEDICAL & URGENT CARE CENTER, INC
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Print Patient full name

_____/_____/_____
Birth date (Mo/Day/Yr)

Street address

_____-_____-_____
Social Security Number

City/State/Zip code

(_____)_____-_____
Phone (Home)

(Parent / Guardian if Patient <18 yrs)

At the request of the individual, I _____, do hereby authorize **Nova Medical & Urgent Care Center, Inc.** to release:
(patient name)

SERVICE DATES REQUESTED _____

_____**LAST TWO YEARS** _____ Pathology Reports _____ EKG / EEG / CATH
_____**History & Physical** _____ Laboratory Reports _____ Entire Chart
_____**Progress Notes** _____ Radiology Reports _____ Other _____

_____ **I do** _____ **I do NOT** **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.**

INFORMATION
RELEASED TO: _____
Name of Company/Agency/Facility/Person

Street Address

City/State/Zip

_____ *CHECK HERE for e-Delivery, completion of additional form required*

PURPOSE OF DISCLOSURE:
_____**Referral to Specialist** _____ **Insurance** _____ **Workers Comp** _____ **Leaving Practice**
_____**Legal Investigation** _____ **Disability Determination** _____ **Self** _____ **Relocation / Moving**
Other (please specify) _____

Please provide current 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 affect any information released 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 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.

NOTE: Virginia law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia rates are pgs 1 - 50 at \$0.50 per pg, pgs 51+ at \$0.25 per pg. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

**Signature of patient or guardian or
Personal Representative of patient's estate (Power of Attorney must be attached)** Date _____

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ EKG _____ PATH _____
DS _____ EKG _____ IMMUNE _____ H&P _____ _____
OP _____ X-RAY _____ OTHER _____ ROI Specialist Date