Authorization to Release Protected Health Information

I hereby authorize FairfaxMD, PLLC to release a copy of my medical records according to the instructions below. Mail completed form to: FairfaxMD, PLLC, PO Box 3804, McLean VA 22103 or email to: inbox@fairfaxmd.com

Patient		Date of Birth	/ /
Address			
City/State/Zip			
Mobile Phone #		Other Phone #	

Release my records to

Address	
City/State/Zip	
Phone #	Fax #

Information to be released *select one*

☐ **Last 2 years** of records (almost always sufficient) including

Progress notes EKGs & cardiovascular testing Radiology reports Other diagnostic tests
Labs Immunizations Consultations Plus anything else your physician deems important

☐ **Complete record** *(Please be aware that multi-year charts can contain hundreds of pages & result in fees approaching $100 or more)*

☐ **Other** (specify types of records & time range)

Select one: ☐ **I do** ☐ **I do NOT**

authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), psychiatric and/or psychological assessment, and treatment for alcohol and/or substance abuse

This authorization for the release of my records is effective until _____ or will expire in one year from the date signed below, whichever comes first. I understand that I may revoke this authorization in writing at any time.

Choose one of the following:

☐**Digital format (CD)**: $0.37 per page for the first 50 pages and $0.18 per page for each additional page. A processing fee & shipping cost for mailed records will be added.

Note: Some practices such as Inova, Fairfax Family Practice, and VHC will not accept CDs We will then automatically fax or mail records.

☐**Faxed or mailed paper documents**: $0.50 per page for the first 50 pages & $0.25 per page for each additional page. Records will be mailed if unable to send by fax delivery A processing fee & shipping cost for mailed records will be added.

Signature of patient *Date*

Signature of patient's legal representative *Relationship to patient*