

CHARLOTTESVILLE WELLNESS CENTER
FAMILY PRACTICE
PREVENTATIVE MEDICINE

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MEDICAL RECORDS RELEASE AUTHORIZATION

I AUTHORIZE RELEASE OF MEDICAL RECORDS:

TO/FROM:

Dr. or Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

FROM/TO:

Charlottesville Wellness Center
901 Preston Avenue, Suite 300
Charlottesville, VA 22903
Phone: (434) 977-3140
Fax: (434) 977-4984

To include:

_____ Doctor's Notes

_____ HIV Testing

_____ Psychological

_____ Substance Abuse

_____ Radiological

_____ All of the above

Other (Specify) _____

Patient's Name (Print)

Patient's Date of Birth

Witness

Patient's Social Security Number

Patient/Guardian Authorizing Signature

Date

I expressly consent to the release of the information designated above. I understand and acknowledge that my authorization includes all parts of the records as states, including treatment for mental illness, alcohol, drug abuse, and HIV/ARC/AIDS. A copy of this authorization is as valid as the original. This release is valid for 180 days from date of signature and may be revoked at any time in writing by the patient or legal guardian. This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Copies of medical records not intended for medical use may be subject to minimal charges.