PATIENT LABEL

Release of Information

1010 N. Thompson Street
Richmond, VA 23230
Phone: (804) 358-6343

☐ **Medical Clinic FAX: (804) 864-2586**

☐ **Mental Health Clinic FAX: (804) 354-9124**

health brigade
formerly Fan Free Clinic

CONSENT TO RELEASE OR OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION

CHECK ONE ☐ **Obtain From** ☐ **Release To**

'rint Patient's Full Name _____ Date of Birth M/D/Y _____

treet Address _____ Phone _____

ity, State, Zip Code _____

mail address _____

Name _____

Street Address _____

City, State, Zip Code _____

Fax (For Continuity of Care Only) _____

I, _____ **hereby authorize Health Brigade to release or to obtain the health informa**
indicated below that is contained in my patient record. I understand and acknowledge that this may include physical and mental illr
alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnoses.
INDICATE APPROXIMATE DATE(S) OF SERVICE: _____.

Information to be Released or Obtained

☐ All	☐ Laboratory Reports	☐ Other:
☐ Bone densitometry	☐ Mammograms/Breast Imaging	
☐ Cardiac Studies/EKGs	☐ Mental Health Records	
☐ Clinic & Progress Notes	☐ Operative Reports	
☐ Discharge Summaries	☐ Radiology Images	
☐ ER Visits	☐ Radiology Reports	
☐ History and Physical	☐ Pap/Colposcopy Reports	
☐ Hospital Notes	☐ Pathology/Biopsy Reports	
☐ Immunization Records	☐ Psychotherapy Notes	

understand that I have the right to revoke this authorization, at any time, except to the extent that action has already been taken. My evocation will not be effective until delivered in writing to the person who is in possession of my records. A copy of my revocation shall be naintained. Information disclosed pursuant to the authorization may be re-disclosed by the recipient and is no longer protected by federal rivacy regulations. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
This authorization will expire 12 months from the date of signature unless I indicate an earlier date here: _____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

Patient Signature _____ Date Signed (M/D/Y) _____

Printed Name of Person Signing _____

Mailing Address _____