

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

PATIENT LABEL

CONSENT TO RELEASE OR OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION

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

Street Address _____ Phone _____

City, State, Zip Code _____

Email address _____

CHECK ONE Obtain From Release To

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 information indicated below that is contained in my patient record. I understand and acknowledge that this may include physical and mental illness, alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnoses.

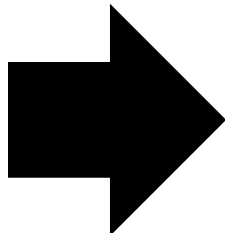
INDICATE APPROXIMATE DATE(S) OF SERVICE: _____

Information to be Released or Obtained

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

I understand that I have the right to revoke this authorization, at any time, except to the extent that action has already been taken. My revocation 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 maintained. Information disclosed pursuant to the authorization may be re-disclosed by the recipient and is no longer protected by federal privacy 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