



Authorization for Release of Information – External to Internal

Patient Name: _____ Date of Birth: ____/____/____

I hereby authorize: *(Enter the name of the agency/individual form which information is being requested)*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____)____-____ Fax: (____)____-____

To release information from my medical records to:

PATHS Community Medical Center
705 Main Street
Danville, Virginia 24541
Voice: 434-791-4122
Fax: 434-791-4126

PATHS Community Medical Center
287 Commonwealth Blvd.
Martinsville, Virginia 24112
Voice: 276-632-2966
Fax: 276-632-0841

PATHS Community Dental Center
705 Main Street
Danville, Virginia 24541
Voice: 434-791-0214
Fax: 434-791-0217

PATHS Community Medical Center
4 South Main Street
Chatham, Virginia 24531
Voice: 434-432-4443
Fax: 434-432-3555

PATHS Community Medical Center
380 Washington Street
Boydton, Virginia 23917
Voice: 434-738-6420
Fax: 434-738-6054

PATHS Community Dental Center
380 Washington Street
Boydton, Virginia 23917
Voice: 434-738-6420
Fax: 434-738-6054

PATHS Community Pharmacy
705 Main Street
Danville, Virginia 24541
Voice: 434-791-4880
Fax: 434-792-1725

PATHS Community Medical Center
1627 Seymour Drive
South Boston, Virginia 24592
Voice: 434-575-1336
Fax: 434-575-1349

I specifically authorize the release of information relating to:

Date(s):

- Health & Physical Exams _____
- Progress notes _____
- Lab Report(s) _____
- X-ray(s) _____
- Other: _____

- Substance Abuse treatment (including alcohol/drug abuse)
- HIV/Related information (including AIDS related testing)
- Mental health treatment (including psychotherapy notes)

PURPOSE OF DISCLOSURE:

- Changing providers
- Legal reason
- Consultation/second opinion
- School issue
- Continuing care
- Insurance issue
- Other:

1. I understand that this authorization will expire upon receipt of the requested information, or on ____/____/____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that by authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this.

Patient/Legal Guardian's Signature

____/____/____
Date

Relationship to patient, if signed by someone other than the patient.