Print Form

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Doctor, Hospital, Health Department or Other Agency

_____

Street Address

_____

City, State, Zip Code

I hereby authorize and request you to Mail or Fax medical information to:

One Care Medical
13895 Hedgewood Drive, Suite 101
Woodbridge, VA 22193

Phone (703) 649-3803
Fax (703) 546-4259

PERMISSION FOR RELEASE OF INFORMATION

I (patient's name): _____

Date of Birth: _____ SSN: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PLEASE SEND THE FOLLOWING SPECIFIC INFORMATION CONCERNING MY ILLNESS AND/OR TREATMENT:

☐ All Records ☐ Dates of Treatment : From _____ To _____

☐ Specific Information: _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and thereby release One Care Medical and its staff from all legal responsibility that may arise from the act hereby authorized. I understand that I may revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. This release is effective for six months from the date signed.

If the patient has reached his/her 14th birthday, **only** the patient may authorize disclosure relating to sexual diseases.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT OR LEGAL GUARDIAN: _____ DATE: _____