Authorization for Release of Medical Information

1420 Beverly Road, Suite 110 McLean, VA 22101 Phone: 703-260-6455 Fax: 703-995-4330
ExecutiveMD.com

Patient's Name_____ D.O.B._____
Address: _____ Social Security # _____
_____
_____
Phone: _____

I, _____, do hereby authorize _____
to release the below mentioned records. I realize that by signing this I authorize this release of health information. This authorization is valid for 12 months from the date signed. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it. I understand I may cancel this request at any time with written notification

Records to Be Released:
___All records
___History and Physical/Progress Notes
___ Consultation Notes
____Others:_____
____All Emergency Room Records
____Laboratory/Radiology Records

___ I do ___ I do NOT authorized release of information related to (check that which applies):
___ AIDS or HIV infection
___ Psychiatric care and/or psychological assessment
___ Treatment for alcohol and/or drugs

Purpose of Disclosure:
___ Specialist Referral
___ Continuing Care
___ Others: _____
___ Updating Personal Records
___ Change of Doctors

I understand there may be a charge for record copying services and I am responsible for paying for these fees.

Information May Be Released to:

Dr. John Mamana
Executive MD
1420 Beverly Road, Suite 110
McLean, Virginia 22101
703.260.6455

PLEASE FAX RECORDS TO US AT: 703.995.4330

I authorize the above specified release of information regarding myself or my legal guardian.

Signed: _____ Date: _____

Print: _____