# MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION FORM at the GW Medical Faculty Associates

**Patients/Physicians**
**Mail Request to**
**2150 Pennsylvania Ave,**
**NW Suite G-206**
**Washington, DC 20037**
**Phone: 202.741.2404**
**Fax: 201.741.2405**

**Insurance/Law Firm or Agent/Other**
**Mail Request to**
**2021 K Street NW,**
**Suite 408**
**Washington DC, 20006**
**Phone: 202.741.2404**
**Fax: 202.741.2431**

## PLEASE PRINT

Patient Name: _____

Date of Birth: _____ Medical Record Number (Optional): _____

Address: _____

_____

Phone: _____ Email: _____

## **THERE MAY BE A CHARGE FOR RELEASE OF MEDICAL RECORDS**

**The purpose of this request for medical records is: (Check all that apply):**

☐ Patient's request - Continuation of care/transfer of care/Second opinion

☐ Attorney/legal request

☐ Insurance – Worker's Compensation/Claims/Long & short-term Insurance

☐ Disability Claim

☐ Other: _____

**Information to be disclosed**:

☐ ALL RECORDS

☐ LABORATORY/PATHOLOGY RESULTS

☐ RADIOLOGY (X-RAY) RESULTS

☐ RECORDS OF (Name of Provider or Department) _____

☐ OTHER _____

**This authorization is limited to the following dates of treatment:**

FROM _____ TO _____

**This authorization expires on: _____ (specify date or event)**
**If the expiration date is left blank, the authorization will expire 60 days from the signature date

**********

**Preferred method of delivery:**

☐ U.S. Mail: To this address: _____

_____

☐ Pick up in person: (A government issued picture ID will be **REQUIRED**)

☐ Fax to Physicians Office: (Phone) _____ (Fax) _____

**ADDITIONAL IMPORTANT INFORMATION**

**Information disclosed may include personal health information, such as your identity, diagnosis, and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.**

- You have a right to revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization;
- The information released in response to this authorization may be re-disclosed to other parties;
- Your treatment or payment for treatment cannot be conditioned on the signing of this authorization.

SIGN HERE

**Patient's Signature:** _____

**Date of Request:** _____

**IF THE REQUESTOR IS NOT THE SUBJECT OF THE RECORDS:**

IF YOU ARE REQUESTING MEDICAL RECORDS FOR SOMEONE OTHER THAN YOURSELF, YOU MAY BE REQUIRED TO PROVIDE ADDITIONAL DOCUMENTATION TO SHOW YOU HAVE THE LEGAL RIGHT TO REQUEST THE RECORDS.

Legally Authorized Representative's name: _____

Representative's signature: _____

Relationship/Authority to request or sign on patient's behalf: _____

**********

**OFFICE USE ONLY:**

Person verifying identity:_____ Method of verification: _____

Date of verification:_____ Comments:_____