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: 202.741.2405

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: ____

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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

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Preferred method of delivery:

☐ U.S. Mail: To this address: ____

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☐ 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.

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: _____________________________

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OFFICE USE ONLY:

Person verifying identity:_____________________ Method of verification: ____________________

Date of verification:_________________________ Comments:_____________________________