FAMILY MEDICINE at Lansdowne

RELEASE OF PROTECTED HEALTH INFORMATION

Completing this form gives our office permission to obtain your medical records from the providers you list below. You are not required to agree to the release of your medical history, although, you should be aware that this may limit our ability to provide you with appropriate care.

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information for the patient named above to:

Name: **Robert Saunders MD Tel: (703) 726-8687 Fax: (703) 726-0081**

Address: **Family Medicine at Lansdowne**

City: **Lansdowne** State: **VA** Zip Code: **20176**

This request and authorization applies to (check one):

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

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☐ Other: ____

☐ Yes ☐ No I further authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

Printed name: ______________________

THIS AUTHORIZATION REMAINS VALID FOR ONE YEAR AFTER IT IS SIGNED UNLESSREVOKED SOONER.

Our FAX is (703) 726-0081