Authorization to Release Confidential Medical Information

I, _____ authorize the following:

FROM:

Name of Doctor's Office: _____
Name of Physicians: _____
Street Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

TO:

WeCare
Medical Associates

611 Jefferson Davis Hwy Ste101 Fredericksburg, VA 22401 wecarema.com
www.facebook.com/wecaremallc
Phone: 540.656.2950 Fax:540.656.2957

Patient Name: _____
Date of Birth: _____

Information to be Released (check all that apply):
____Summary ____Med List ___Last 2 Office Visits
____ Last Set of Labs (CBC,CMP, TSH, Vitamin D, ETC)
___Specialist Consult

Comments: _____

VA law allows for copy charges of the following: $10.00 administrative free PLUS $.50 per page for the first 50 pages and $.25 per page thereafter, and $1.00 per page of microfilm/fiche. I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release WeCare Medical Associates to from, and release and covenant not to sue WeCare Medical Associates for any claim that I have or may have in the future for release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may request to inspect or copy information at any time except where actions have already been taken on the basis of the release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event, or condition described as:

Patient Signature/Responsible Party: _____ Date: _____
Witness Signature _____ Date: _____