Ashcake Family Physicians
7493 Right Flank Road, Suite 400
Mechanicsville, VA 23116
Phone: (804) 559-2916 Fax: (804) 559-9206

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, (Patient's name): _____
Address: _____
Street Address City State Zip
Telephone: _____ Date of Birth: _____ Social Security Number: _____
Please print any previous names under which records may be found:
_____

2. Hereby authorize ____ AFP ____ (Other) _____

3. To release the following information: _____

Records of other providers on file with AFP (if any), (We must impose our standard copying fees. AFP does not represent that these records are the complete records of the other providers. If you want a complete copy of the records created by the other providers for this patient, you may wish to contact each provider.) I understand that if the records requested to be released include information relating to sexually transmitted disease, AIDS or HIV, alcohol or drug abuse, or mental health information, this information may be released pursuant to this authorization.

4. To: Ashcake Family Physicians _____ Myself _____
Other _____

5. Purpose of access or release: _____ Medical Care; _____ Insurance or Other Payment;
____At Request of the Patient; ____Other (explain) _____(3/2005HIPAA)

I understand the following: (A) the nature of the information to be released; (B) to whom the information is being released; (C) why the information is being requested/released; (D) once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations; and (E) repercussions which might occur due to my release of or failure to release the information specified above have been explained to me. I also understand that I may refuse to release confidential information or revoke this authorization at any time by giving written notice to AFP. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization. AFP, its employees and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. AFP will not condition treatment, payment, enrollment, or eligibility for benefits on your signing of this authorization. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by AFP to provide the copies requested. This authorization will expire in 90 days from the date on which it was signed unless I specify a shorter time period.

Expiration date or event: _____
Patient's Signature _____ Date signed _____
Witnessed by: _____ Type of identification presented: _____