PHOENIX HEALTHCARE OF VIRGINIA, LLC
Sondra B. Harry, PsyD
904 Princess Anne St., Ste. 301 Fredericksburg, VA 22401
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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL MEDICAL INFORMATION

I, ___________________________DOB_____/______/______SSN_____/______/______
ADDRESS____________________CITY__________________STATE________________
ZIP CODE_________________PHONE (H) __________________(C) __________________

I am requesting Phoenix HealthCare of Virginia to:
I authorize Phoenix Healthcare of Virginia to disclose information on my protected health care to the following person (s)
( ) Spouse____
( ) Other ____ (please specify)
____
Valid through (dates) _______________________ or indefinite†
RELEASE YOUR RECORDS TO:
( ) I, authorize Phoenix HealthCare of Virginia to RELEASE the information to, in accordance with the laws of the Commonwealth of Virginia and Phoenix HealthCare of Virginia policies:
NAME.ORGANIZATION____
ADDRESS____CITY_____________________
STATE___________ZIP CODE________________________PHONE________________________
FAX_____________________________________

OR
TO OBTAIN RECORDS FROM:
( ) Authorize Phoenix HealthCare of Virginia to OBTAIN medical information from:
NAME.ORGANIZATION____
ADDRESS____CITY_____________________
STATE___________ZIP CODE________________________PHONE________________________
FAX_____________________________________
Please send to: 904 Princess Anne St., Fredericksburg, VA 22401

INFORMATION TO BE RELEASED OR OBTAINED:
Physician notes__ Radiology reports__ Hospital records__ Lab reports__
Emergency room reports__ History and physical__ HIV records __Consultation__
Drug and alcohol __Psychiatric notes__ Complete chart __
Other_______________

Dates of Service ________________to________________________

The purpose for this disclosure of the above information is:
__Continuing Care__ Personal Use__ Other_____________________

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter and $1.00 per page microfilm/fiche.
I hereby authorize, allow and cause the release the information indicated above. No threat of utter coercive measures have induced me to sign this form and I do release Phoenix HealthCare of Virginia from and covenant not to sue Phoenix HealthCare of Virginia for any claim I have or may in the future for the 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 any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no

longer protected by those regulations. I further understand that I may revoke this consent to release information at ay time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire in 6 months after the date specified below, or on the date, event or

Signature: ____Date:__________________________