

SELMA MEDICAL ASSOCIATES, INC. - Health Information Management

104 SELMA DRIVE, WINCHESTER, VA 22601

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INTERNAL MEDICINE - INFECTIOUS DISEASE - CARDIOLOGY- FAMILY PRACTICE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Request: _____

Date of Birth: _____ Medical Record Number: _____

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individual or organization is authorized to make the disclosure:

Facility/Doctor/Hospital Name _____

Full Address including City, State/Zip Code _____

- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Problem List/Core Data Sheet	___ Most recent History & Physical
___ Medication List	___ Most recent Progress Note/Office Visit
___ List of Allergies	___ Consultation Reports
___ Immunization Record	___ Entire Record

___ Other Physician/Hospital Records from: _____

___ Laboratory Results - Dated _____ to _____

___ X-ray Reports - Dated _____ to _____

___ Other _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

- This information may be disclosed to and used by the following individual or organization:

**Selma Medical Associates, Inc.
104 Selma Drive
Winchester, VA 22601**

for the purpose of:

(OVER =>)

