ROCKBRIDGE HEALTH PLLC

650 N. LEE Highway, Suite2
Lexington, Va 24450
Phone: 540-463-0951
Fax: 540-463-0954

RELEASE OF MEDICAL RECORD AUTHORIZATION

Patient Name:_____ DOB:_____
Address:_____ City:_____ State:_____ Zip:_____
SSN/ DL#_____ Phone:_____

I authorize : RockbridgeHealth PLLC
650 North Lee Hwy Suite 2
Lexington, VA 24450

_____Scott B. Dubit M.D
_____Patricia L. Schirmer M.D
_____Carola Tanna M.D
_____Zachary Dubit M.D

To:(please check one)

__ Obtain protected health information **FROM** the following location
__ Release my RockbridgeHealth protected health infromation **TO** the following

Name:_____
Address:_____City:_____State:____ Zip_____
Phone:_____ Fax:_____

Information to be released/received:

__All Medical Records_____
__ Only medical records from (specify provider)_____
__Only medicla records relatedto (specify provider)_____
__Only lab tests (specify)_____
__Only imaging (specify)_____
__ Pap/Annual exam (most recent)_____
__Other request_____

Purpose of disclosure:_____

Medical records are defined as : All health information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes healthcare information associated with drugs/alcohol abuse, mental or psychiatric care, abortation , and HIV status and /or diagnosis of AIDS and /or other sexually transmitted disease include hepatitis, unless restricted above.

If one of the above facilites is requesting this authorization to be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for the health care will not be affected.
I understand that this authorization may be revoked by me at any time, provided that I do so in writing and send it to medical records department , up to the exent that disclosure has not already been made. I als understand that my protected health information may not be re-disclosed by the reciepient without my further written consent unless provided by state and federal law. Authorization will expire in 6 (six) months unless otherwise specified. Expiration date:_____
Patient Signature(if over 18)_____ Date:_____
Or
Legal Representative /Guardian:_____Date:_____
Relationship to patient_____
Witness:_____
Request sent : Mailed _____Faxed:_____ Date _____ By:_____

Authorization is HIPAA compliant (2016)