AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: ______________________ ______________________ ___ ______________________
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ______________________ **PHONE #:** (______) ______________________
MO DAY YR

PATIENT ADDRESS: ______________________

CITY: ______________________ **STATE:** ______________ **ZIP CODE:** ______________

PATIENT EMAIL: ______________________

I hereby authorize ______________________ (Print The Name of Your PREVIOUS Provider(s) or Medical Organization Here) to release my medical records and/or items checked below to:

NAME: **Angie Tucker Anderson MHA, FNP-BC, Journey Health & Wellness LLC**

ADDRESS: 2200 Pump Road, Suite 101 CITY: Henrico STATE: VA ZIP: 23233

PHONE: ______________________ **FAX: 804-207-8855**

INFORMATION TO BE RELEASED:

- ❑ Medical Record Date(s): ______________________
  - ☐ Entire Record Year(s): ______________________
- ❑ X-rays/Imaging/EKG Date(s): ______________________
- ❑ Labs Results Date(s): ______________________
- ❑ Vaccine Records Date(s): ______________________
- ❑ Other: ______________ Date(s): ______________________

PURPOSE OF DISCLOSURE: ❑ Changing provider(s) or Following Provider(s) ❑ Insurance Requirement
❑ School/Sports ❑ Legal or Workers Compensation
❑ Other (please specify): ______________________

- I understand that if Journey Health & Wellness LLC has requested this authorization then I will receive a copy of this form after I have signed and dated it. Copying charges may apply.
- I understand that this authorization will be valid for one year.
- I understand that I may revoke this authorization at any time by notifying Journey Health & Wellness LLC in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information disclosed to the above individual or organization may be redisclosed by the recipient and may not be protected by Federal or State Privacy Rules.
- I understand that my right to receive medical services from Journey Health & Wellness LLC will not be affected if I refuse to sign this authorization.
- I understand that if my record contains information related to substance abuse, HIV related information, sexually transmitted diseases, genetic testing results, and/or psychotherapy notes and other mental health information, that information will be released with my medical record, subject to and consistent with applicable State law requirements.

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so.

______________________ ______________
Signature of Patient/Legal Guardian/Personal Representative (Relationship to the Patient) Date

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Instructions: **Please Fax to 804-207-8855 or Mail to:**

Attn: Medical Records Office, Journey Health & Wellness LLC
2200 Pump Road, Suite 101 • Henrico, VA 23233