RELEASE OF MEDICAL INFORMATION AUTHORIZATION TO DOCTALKER

By signing this form, I authorize DocTalker Family Medicine to request the release of my confidential health information from the physician/person/facility/entity listed below. Authorization to make such requests for records terminates two years following the last date of service.

Patient Name: _____ Date of Birth: _____

Address: _____

Contact Phone: _____ E-mail: _____

The information you may release subject to this signed release form is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes	□ Care plan
□ Lab Reports	□ Radiology Reports	□ Pathology Reports	□ Treatment Record
□ Operative Reports	□ Hospital Reports	□ Medication Record	□ Other (Specify below)

_____

Release of health information from:

Facility/Physician Name: _____ Contact Phone: _____
Address: _____ Fax: _____

Release my protected health information to the following:

DocTalker Family Medicine
370 Maple Ave W, Suite V
Vienna VA 22180
P: (703)-938-4604
F: (703)-938-4618

Signature: _____ Date: _____

Requesting the release of highly sensitive information such as HIV/alcohol/ psychiatric history in your record needs another authorization signature.

I authorize the release of highly sensitive information including (state specifically what tests or records are requested):

Signature: _____ Date: _____

Name (printed): _____ Relation to Patient: _____

Submit

(must have Adobe Reader)
or send to info@doctalker.com