ROYAL OAK MEDICAL ASSOCIATES, P.C.
SMYTH COUNTY FAMILY PHYSICIANS DIVISION
1616 N. MAIN ST., MARION, VIRGINIA 24354
FAX: 276-783-1820 PHONE: 276-783-8123

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

FORM EFFECTIVE DATE: APRIL 14, 2003

I hereby authorize use or disclosure of the named individual's health information as described.

Patient Name:_____ **Date of Birth:**_____
Address: _____ **SSN:**_____
_____

The following physician and/or organization is authorized to make the disclosure:

_____
and release the medical information to_____
_____

Treatment Dates: From:_____ To:_____

The following information is to be disclosed:

Yes	No		Yes	No	
___	___	Physician Notes	___	___	History & Physical
___	___	Consultation Reports	___	___	X-ray Reports
___	___	Discharge Summaries	___	___	Progress Notes
___	___	Laboratory Results	___	___	Photos/Other Images
___	___	Complete Health Record	Other:_____		

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied: (b) I understand that I may inspect or obtain a copy of the information that is to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. **(If I do not specify an expiration date, event or condition, this authorization will expire in six months.):**

_____

_____ _____
Signature of patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient