SETH TUWINER, M.D
Loudoun Medical Group, PC
Phone (703)-293-5244
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____/_____/_____
Print Patient full name Birth date

_____ _____-_____-_____
Street address Social Security Number

_____ (_____)_____-_____
City/State/Zip Home phone number

At the request of the individual, I_____, do hereby authorize

_____to release:

_____Venereal Disease	_____Other Infectious Disease	
_____Discharge Summary	_____Pathology Reports	_____Emergency Reports
_____History & Physical	_____Laboratory Reports	_____Other _____
_____Progress Notes	_____Radiology Reports	_____
_____Operative Notes	_____ECG/EEG/Cardiac Cath	_____

PLEASE RELEASE INFORMATION TO:

_____
Name of Company/Agency/facility/Person

_____
Street Address

_____
City/State/Zip

PURPOSE OF DISCLOSURE:

____Referral to specialist	____Insurance	____Workers Comp	____Change of Doctor/Provider
____Legal Investigation	____Disability determination	____Personal	____Continuing care

____Other(please specify)_____

Please provide the best telephone number in the event we need to contact you (home or work or cell) (_____)_____-_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished many not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**