Rockbridge Area Health Center

25 Northridge Lane
Lexington, VA 24450
Phone: 540-464-8700
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www.rockahc.org

Medical and Behavioral Health patients only:

HIPAA RELEASE OF INFORMATION FORM

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Date of Birth: _____ Age: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____

I give permission to the Rockbridge Area Health Center to use and *(choose one)*:

☐ Send my RAHC records to ☐ Receive my records from

_____ _____
Name of Facility or Person Phone Number/ Fax Number

_____
Street Address City State Zip Code

Dates ranging from _____ to _____
If no date has been specified, only provide the last 2 years

I am requesting the following documentation to be released: (check all that apply)

☐	All Records	☐	Physical Therapy Notes	☐	Physician Office Notes	☐	EKG Reports
☐	Lab Results	☐	Immunization Record	☐	Pharmacy Records	☐	Other:
☐	X-Ray Results	☐	Mental Health Record	☐	HIV/AIDS Info	☐	

The purpose for the release of information at the request of the individual is: (check one)

☐	Transfer of Care*	☐	Disability	☐	Self/Personal Copy	☐	Other:
☐	Insurance	☐	Workman's Comp	☐	Attorney	☐	

***If Transfer of Care is checked, RAHC will become my Primary Medical Care Provider.**

I understand that I have the right to revoke this authorization by submitting my request in writing. I further understand that Rockbridge Area Health Center may re-disclose records received under this authorization, except for mental health records which require a separate re-disclosure authorization. I also understand that I may refuse to sign this authorization and it is strictly voluntary. But, I also understand that certain records are needed for the best quality medical care. I fully understand and accept the terms of this authorization.

_____
Patient/Legal Guardian Signature

_____ _____
Relationship to Patient Date

This authorization shall remain in effect one year from the date of the request unless otherwise stated.