William Sawchuk, M.D. **Gayle Masri-Fridling, M.D.**
8320 Old Courthouse Road, Suite 303
Vienna, VA 22182
Phone: (703) 532-7211 Fax: (703) 534-2874

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_____ Date of Birth_____/_____/_____

Street Address:_____

City:_____ State:_____ Zip: _____

I authorize the following individual or organization to disclose the above-named individual's health information:

☐ Dr. Sawchuk Address: 8320 Old Courthouse Road, Suite 303, Vienna, VA 22182

This information may be disclosed TO and used by the following individual or organization:

_____

Street Address:_____

City:_____ State:_____ Zip: _____

Please release the following:

☐ Office Visit Notes (From:____/____/____To:____/____/____) ☐ Pathology Reports ☐ Lab Reports Blood Tests

☐ Other: _____

For the purpose of:

☐ Personal Record ☐ Transfer of Care ☐ Copy for Primary Care Physician ☐ Other:_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold_____ liable for any misunderstanding of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed_____/_____/_____ # of Pages Copied: _____
Charges $_____Payments $_____ (_____Cash_____Credit Card_____Check #_____) Initials_____