ALEXANDRIA PRIMARY CARE ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S FULL NAME

SOCIAL SECURITY NUMBER | DATE OF BIRTH (MM/DD/YYYY)

STREET ADDRESS

CITY, STATE, ZIP

EMAIL ADDRESS | PHONE NUMBER

I AUTHORIZE ALEXANDRIA PRIMARY CARE ASSOCIATES TO RELEASE ANY AND ALL MEDICAL RECORDS INDICATED BELOW TO:

NAME OF COMPANY/AGENCY/FACILITY/PERSON

STREET ADDRESS

CITY, STATE, ZIP

PATIENT OR AUTHORIZED INDIVIDUAL SIGNATURE | DATE

Alexandria Primary Care charges a processing fee of $10 plus $.50 per page for copying medical records.

Please indicate the Medical Records you want released:

____ALL	____EMERGENCY REPORTS	OTHER:_____
____DISCHARGE SUMMARY	____PATHOLOGY REPORTS	
____HISTORY & PHYSICAL	____LAB REPORTS	_____
____PROGRESS NOTES	____RADIOLOGY REPORTS	
____OPERATIVE NOTES	____ECG/EEG/CARDIAC CATH	_____

____I DO ____I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/ or psychological assessment, and treatment for alcohol and/or drug abuse.

Mail to: Alexandria Primary Care Associates; Attn: Medical Records; 4660 Kenmore Ave, Suite 710 Alexandria, VA 22304
Email to: AlexPrimaryCare@gmail.com