



Gail Dolan MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
To release healthcare information of the patient named above to:

Name: Bristow Pediatrics

Address: 10492 Bristow Center Dr.

City: Bristow State: VA Zip Code: 20136-2202

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

As the person signing this authorization, I understand that I am giving my permission to the above named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless specific circumstances under which such conditioning is permitted by law are applicable and set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to the records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included in my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Patient Signature: _____ Date: _____

Relationship to Patient: _____