AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Name:____________________DOB:_____________SSN:________________

This authorizes E. Virginia Bayliss, M.D. to _____ send to and/or _____ receive from:

(PCP) NAME:____

ADDRESS:____

TELEPHONE:____

The following information:
( ) Evaluation
( ) Treatment
( ) Other______________________________________

For the purpose of:
( ) Coordination of care
( ) Other______________________________________

☐ **I DECLINE TO AUTHORIZE E. VIRGINIA BAYLISS, M.D. TO COMMUNICATE WITH MY PRIMARY CARE PHYSICIAN.**

Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified. No one may re-disclose this information without my permission. However, I am aware that once protected health information is copied and released, it is possible for this information to be re-disclosed by the organization that receives it, and E. Virginia Bayliss, M.D. cannot be held liable if this occurs.

This space may be used for any limitations or restrictions regarding this release:

____

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____________________________ ____________________________
Date of Signature Signature of Patient

____________________________ ____________________________
Relationship to Patient Signature of guardian or next-of-kin in cases of minors or those declared incompetent.

____
Signature of Witness

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Charlottesville, VA 22911
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Fax (434) 296-1195