Drs. Paquin & Panner, P.C.
7771 Ashton Avenue
Manassas, VA 20109
(703) 361-8284
(703) 361-0318 (fax)
Contact: Kimberley Watson

AUTHORIZATION FOR REQUESTING IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient address _____

Patient phone number _____

I authorize the office of _____
(Provider's Name)

to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] **to Drs. Paquin & Panner, P.C.,** at the location noted above, under the following terms and conditions:

1. **Detailed description of the information to be released:**
   □ Examination Records □ Billing Records □ Specify_____
2. **The purpose(s) for the release:**
   □ By request of the individual □ Specify_____
3. **Expiration date or event relating to the individual or purpose for the release:**
   □ One-time request □ Ongoing request □ Expiration date/event _____

It is completely your decision whether or not to sign this authorization form. Treatment cannot be refused if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if the records have already been released in response to this authorization. If you want to revoke your authorization, send a written note to the provider telling them that your authorization is revoked.

When your health information is disclosed as provided in this authorization, Drs. Paquin & Panner , P.C. may not re-disclose the information to anyone else without your written consent unless that disclosure is specifically permitted by law.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ **Patient signature**_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____