ACHN Clinic
4431 Brookfield Corporate Drive, Unit F
Chantilly, VA 20151
(703) 542-3366 – Office
(888) 965-5824 – Fax
www.achnclinic.com

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Provider's Name: ____

Provider'sAddress:____

Provider's Phone #: ______________________ Fax # of Provider: ____________

Reason for Records Release:____

These records are to be sent to ADAMS Compassionate Healthcare Network at the ACHN Clinic address listed above.

Patient's Name: __________________________Date Of Birth: ______________

Address:________________________________State:________Zip Code:_______

Social Security #: ________________________Phone#:_________________

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record

____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
____Psychological or psychiatric conditions, if any

Other:____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

____________________________________ ____________________
Patients Signature **Today's Date**

____________________________________ ____________________
Patient's Representative Signature **Relationship to Patient**