Edward Wolanski, MD, PC

Edward T Wolanski MD
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Authorization for Use or Disclosure pf Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45C.F.R. Parts 160 and 164)

Patient Information:

Name of Patient _____ Date of Birth_____

Address _____

City, State, Zip _____ Phone #_____

_____ may release the following information:
Name of entity

Adress_____Phone_____ Fax_____

Please check records to be released:

__History and Physical __Laboratory Reports __ Progress Reports __Pathology Reports
__Operative Notes __Radiology Reports __Other _____ __All Records
Time Period from _____ to _____

__FMLA*($15 each form) __ Life Insurance* ($15.00 each form) __Aflac*($10each form) __Disability Form*(15.00 each form)

Entity or Person who will receive the information:

Name_____
Address _____
City, State, ZIP_____
Phone _____ Fax_____

(Initial One) ___I DO ___I Do Not Authorize the release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

(Initial) ___I understand that Edward T. Wolanski MD PC will provide this information within 15 days from receipt. I understand I may revoke this authorization at any time by notifying Edward T. Wolanski MD PC in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking. I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal/state law.

(Initial)___*Fees may apply for record copying and completing forms as requested. I agree to be responsible for payment for service. Fee for preparing and furnishing this information will be charged according to the rulings set forth by the Virginia Statutory Code.

_____ DATE _____
Signature of Patient or Personal Representative

_____
Description or Personal Representative's Authority (Attach Necessary Documentation)