

**Edward Wolanski, MD, PC**

Edward T Wolanski MD

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**Authorization for Use or Disclosure of 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

Address \_\_\_\_\_ 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)