Northern Virginia Psychiatric Group, P.C.
8500 Executive Park Ave, Suite 200 Fairfax,
VA 22031

Patient Authorization to Use or Disclose Health Information

I, _____, understand NoVaPsy is authorized by me to use or disclose my protected health information. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of NoVaPsy, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

[ ] THE PATIENT MEDICAL RECORDS (DOCTORS NOTES ONLY)

[ ] LAB RESULTS ORDERED BY NOVAPSY PHYSICIAN

[ ] Medical Records only related to specific Dates of Service – please indicate below:
Date of Services: _____

[ ] LETTER ONLY - CONCERNING MEDICAL CARE

[ ] VERBAL COMMUNICATION WITH PERSON LISTED BELOW (NO RECORDS TO BE SENT)

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information. This authorization permits NoVaPsy to send the protected health information ONLY to this **address or fax number**:

Release/send to [ ] **Name:**: _____
OR **Address:**_____
Obtain from [ ] _____
FAX#: _____

Purpose(s) of the information: [ ] Transfer of Care [ ]Coordinate Care [ ]Other: _____

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, NoVaPsy must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient date of birth, chart number, if applicable,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

NoVaPsy will accept written revocations of this authorization via: Certified U.S. mail or Facsimile at this number: 703-573-2351.

ALL revocations must be sent to NoVaPsy to the attention of the Privacy Officer, Dr. Richard Baither, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, NoVaPsy can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If left blank release will expire 2 years from date signed.

I fully understand and accept the terms of this authorization.

_____ _____ _____
Patient/ Guardian Signature Patient Date of Birth**(required)** Date

THERE IS A PROCESSING FEE FOR ALL MEDICAL RECORDS REQUESTS. PLEASE LIST A DAYTIME PHONE # SO THAT WE MAY CONTACT YOU DIRECTLY _____

NOVAPSY
NORTHERN VIRGINIA PSYCHIATRIC GROUP, P.C.

SERVING THE COMMUNITY SINCE 1978

DEAR PATIENT:

PLEASE COMPLETE THE FOLLOWING RELEASE OF INFORMATION AND **RETURN IT EITHER BY FAX OR MAIL TO THE ATTENTION OF MEDICAL RECORDS-WENGEL**

Please make sure to complete the entire form and at the BOTTOM OF THE RELEASE PLEASE MAKE SURE TO FILL OUT YOUR CONTACT PHONE NUMBER, so that Medical Records can contact you with any questions or to collect the fee for the copying of your records.

FEES INCURRED FOR REQUESTING COPIES OF YOUR RECORDS:

$15 processing fee
$0.50 per page for (pages1-50)
$0.25 per page for (pages 51-over)

Payment will be due when records are ready for pick up or if you need them mailed a credit card payment will need to be received, prior to records being sent.

MEDICAL RECORDS CONTACT NUMBER: Wengel 703-698-5220 EXT 330

OUR FAX NUMBER IS 703-573-2351 – ATTN: MEDICAL RECORDS/Wengel

EMAIL COMPLETED FORM TO WENGEL: wmengistu@nvpgpc.com

MAILING ADDRESS:
Novapsy – Attn: MEDICAL RECORDS
8500 Executive Park Avenue
Suite 200
Fairfax, VA 22031

Any questions, please contact Medical Records directly.

Thank you for your cooperation.

Novapsy