Colonial Internal Medicine Associates, P.C.
125 Olde Greenwich Drive-Suite 300-Fredericksburg, VA 22408
392 Garrisonville Road-Suite 106-Stafford, VA 22554
Office: (540) 374-5599

Authorization to Use or Disclose Protected Health Information (PHI)

Patient Name: _____Date of Birth: _____/_____/_____

Daytime Phone Number: _____

This authorization permits Colonial Internal Medicine Associates, P.C. to send or discuss your Protected Health Information (PHI) to ONLY the name (s), address or fax number on this form. We cannot discuss your PHI with anyone who is not listed by name on this form.

This authorization shall expire on _____. After this date Colonial Internal Medicine Associates, P.C. can no longer use or disclose the patient's PHI without obtaining a new authorization. If we are providing information to a disability company or attorney, their name and firm name must be listed in the space below. We will only release the medical documentation pertaining to your care by Colonial Internal Medicine Associates, P.C.

List names of those authorized to receive your PHI and their relationship to you. Anyone **not** listed, will **not** have access to your PHI.

1. _____Relationship _____
2. _____Relationship _____
3. _____Relationship _____

May we call you at your place of employment? Yes or No Phone Number:_____

May we leave a detailed labs/x-ray results and Physician instructions on you home answering machine? Yes or No

The patient has the right to revoke this authorization. In order to be effective, it must be in writing. The revocation will take effect on the date both the patient and the practice have signed it. It must include patient's name, address, and phone number. The patient's reason for revocation along with the patient's signature and date of revocation. Mail to Colonial Internal Medicine Associates, P.C. 125 Olde Greenwich Drive-Suite 300-Fredericksburg, VA 22408 Attn: Privacy Officer.

_____ _____

Patient or Legal Guardian (Print) Patient or Legal Guardian Signature

Chart # _____ Date _____/_____/_____