



Piedmont Internal Medicine

"PRIMARY CARE DOCTORS FOR ADULTS"

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TEL: (540) 347-4200

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Patient Name

Date of Request

Authorization for Release of Information

(All information must be completed prior to disclosure of any protected health information)

I hereby authorize Piedmont Internal Medicine to disclose the following protected health information to:

(Physician's name & address or patient's name)

The information to be disclosed should include the following:

Any or all information in my medical record my physician thinks is appropriate

Information limited to dates of service before _____

Information limited to dates of service after _____

Services related to the following: _____

Do **not** send any information relating to

AIDS, ARC, or HIV Infection

Alcohol or Drug Abuse

Mental Health Disorders

Reason for Request:

Medical Request (Continuing Care)

Life/Disability Insurance Request

Health Insurance Request

Personal Request

Legal Request

Other Request

Medical Request (Transferring Care)

If transferring, why?

Changing to a practice out of the area

Changing to a different practice in this area (locally). If changing locally, why?

Insurance - change to:

 Dissatisfied with current physician/practice. Reason: _____

