



Piedmont Internal Medicine

"PRIMARY CARE DOCTORS FOR ADULTS"

419 HOLIDAY COURT, SUITE 100
WARRENTON, VIRGINIA 20186

JOSEPH P. DAVID, M.D.
JAE Y. LEE, M.D.
DEMETRIUS S. MAOURY, M.D.
KEVIN C. MCCARTHY, M.D.
MICHELLE L. PUZIO-BELL, D.O.
WILLIAM L. SIMPSON, M.D., MHSA

TEL: (540) 347-4200
FAX: (540) 341-7102

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:

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 Disorder

Reason for Request:

- Medical Request (Continuing Care)
- Health Insurance Request
- Legal Request
- Medical Request (Transferring Care)
- Life/Disability Insurance Request
- Personal Request
- Other Request

If Transferring, Why?

- Changing to a practice out of the area.
- Changing to a different (local) practice. If changing locally, why?

- Insurance- Changed to: _____
- Dissatisfied with current physician/practice. Reason: _____

