DIRECT ACCESS
INTERNAL MEDICINE

Authorization to Release Medical Records for Continuity of Care

Patient information:

Name:

DOB:

Authorization to Release Medical Records to Direct Access Internal Medicine:

Physician Name: _____

Phone: _____ Fax:_____

**Patient has his/her new patient appointment in our office: _____

___ Last year of Office Notes, Labs, and Medication List.
___ All EKG's, Stress Test, ECHO, US, CT's, Immunizations, Holter Monitor Report, and Op Notes.
___ The last Bone Density, Mammogram, EGD, Colonoscopy, and/or any other pertinent records.

Release to the following:

Direct Access Internal Medicine, LTD
Dr. Ronald Haggerty
Lauri LeBel, FNP
Blair Nein, AGPCNP
6609 Main Street
Gloucester, VA 23061
Fax (804) 694-3174
Phone (804) 824-9153

- I understand that I may revoke this authorization in writing at any time by notifying the same physician or physician group in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state law.

Patient Signature: _____ Date: _____