Colleen A. Blanchfield, M.D.
11490 Commerce Park Drive, Suite 420 Reston, VA 20191
Tel: 703-481-9111 Fax: 703-707-8657

Authorization to Release Protected Medical Information

Patient's Last Name:	First:		Date of Birth:
Street Address:			Home Phone:
City:	State:	Zip Code:	Cell Phone:

I hereby give Colleen A. Blanchfield, M.D. authorization to (specify):

☐ Release Information to *: ☐ Obtain information from:

Company/Provider/Person Name:	
Address:	
Phone:	Fax:

Covering the period(s) of treatment from ________________ to _________________ / ☐ All

Information Requested:	For the purposes of:
☐ Records – Date(s) specified above	☐ Coordination of care with another provider
☐ Lab Work – Date(s) specified above	☐ Moving/Transferring Care
☐ Records DO NOT need to be sent	☐ Insurance/Disability/Legal

☐ Other (specify) ____.

I understand that I must allow a TWO WEEK processing period. *Also, I understand that there will be a fee associated when requesting medical records. The fee (s) associated with this request will be the sole financial responsibility of the patient and/or their authorized representative. There is a reasonable fee consisting of $0.50 per page for the first 50 pages, $0.25 for each additional page, a flat fee of $10.00, plus any postage costs if you request that the copies be mailed. This fee is due in advance of the medical records being released.

I understand that this authorization will expire in **ONE YEAR** unless otherwise indicated here:

☐ Until records are obtained ☐ 6 months ☐ Never ☐ Other: ______________. I understand I may revoke or edit this authorization at any time by providing written notification to Colleen A. Blanchfield, M.D.; however this will not affect actions taken prior to the receipt of my alteration. In the case of a minor, this authorization will expire once the patient turns 18 years of age.

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Printed name of Patient or Authorized Representative

*If you are not the Patient, indicate relationship to Patient: ☐ Parent or Legal Guardian ☐ Power of Attorney

____ ____________________

Signature of Patient or Authorized Representative Date