rejuvinix
NON-SURGICAL JOINT THERAPY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone (H): _ **Phone (M):** _

Street Address:_ **City/State/Zip:**_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

The Above listed patient authorizes the following healthcare facility to make record disclosure:

Rejuvinix
4701 Columbus Street Ste 100
Virginia Beach VA, 23462
(P): 757-772-6066
(F): 757-965-6843

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested.

I understand the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual and used by the following individual or organization:

Release To: _

Address: _

City, State, Zip: _

Fax: _ **Phone:** _

Please mail records ☐ **Please fax records** ☐

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I have read the above foregoing Authorization for Release of Information so hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ **Date:**_____