WILLIAM A. HAMILTON, M.D., F.A.C.O.G.
619 Emancipation Highway, Suite 101
Fredericksburg, VA 22401
Phone - 540-373-4700 FAX 540-373-5635

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient name: _____Date of Birth: _____
Phone #: _____Social Security #: _____

I hereby authorize: Dr. William A. Hamilton
Snowden Office Park
619 Jefferson Davis Highway, Suite 101
Fredericksburg, VA 22401

To forward my medical records to: _____
_____
_____

Please release the records by: □ mailing □ hold for pickup

The specific information to be released includes:

□ Complete Record	□ Operative Reports	□ Hospital Summaries
□ Office Notes	□ Lab/Pathology Reports	□ Ultrasound Reports
		□ Other_____

I □ do □ do not authorize release of information to AIDS (*Acquired Immunodeficiency Syndrome)* or HIV (*Human Immumodeficiency Virus)* infection testing, diagnosis, and/or treatment.

I □ do □ do not authorize release of information related to diagnosis and/or treatment of communicable disease(s), including sexually transmitted disease(s).

I □ do □ do not authorize release of information related to diagnosis and/or treatment of alcohol and/or drug or other substance abuse.

I □ do □ do not authorize release of information related to diagnosis and/or treatment of A psychological, psychiatric or mental health conditions.

The purpose of this release of information is:

□ To process insurance	□ To continue medical care	□ For legal reasons
□ For personal reasons	□ Other reasons (*please specify)*_____	

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above.
I understand that I may revoke this consent at any time except to the extent that the information has already been disclosed. Without my express revocation, this consent will expire 90 days from the date of my signature.
I understand this consent and make this authorization voluntary.

Signature of Patient or Legal Representative: _____Date_____
If patient is a minor, I represent that I am the legal parent /guardian of the minor named and that I am not prohibited by court order from having access to the medical records that I am requesting.
Signature of Parent or Guardian: _____Date_____
Witness: _____Date_____