Diabetes and Endocrine Care of Virginia, LLC
"Excellent care always"

Diabetes and Endocrine Care of Virginia, LLC
9001 Digges Road Suite 101
Manassas, VA, 20110
P:571-363-3082 F:844-634-254

Permission to release information to family members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to a family member you must sign this form. ***There will be a limited time (30 days) for this consent.***

I authorized Diabetes and Endocrine Care of Virginia to release my medical information with the following Individual.

Patients Name	Patients Last Name	Patient's Day of Birth
(Name and Last name) of the authorized individual.		Patient's Phone Number
Name:	Relationship:	
DATE →		

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment alcohol and drug abuse. ***(This part must be signed by the patient).***
Patient Initials(Required):_____ DATE(required):_____

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 Diabetes and Endocrine Care of Virginia. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this request will expire after 30 days from the day of this request has been made. I understand that this form must be fully completed in order to be processed. I understand that this permission of release will not apply for verbally releasing information from the provider and staff. I understand this permission is voluntary and I do not have to release my information, and whatever I decide, it will not affect my health care treatment. I understand that if the provider does not consider my request to release my information necessary, it will be cancelled or denied.
(This part must be signed by the patient).
Patient Initials(Required):_____ DATE(Required):_____

Please disclose/release the following information:

☐Laboratory records ☐Office notes (please write day of service): **From:_____to:_____Year:_____**
☐Pathology records ☐X-ray/radiology records ☐ Pharmacy/prescriptions
☐Other_____

Please note; Diabetes and Endocrine Care of Virginia strictly request to read the following information below:

1. This form needs to be filled out each time that you request your medical record or billing information.
2. Authorized person has to present a legal ID photo.
3. You will need to fill this form if the authorized individual from this request has changed.
4. This permission request will take up to 7-10 business days to be processed.
5. This permission request will **only** be received by fax **844-634-2547** or email at **no-reply@decareva.com.**

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6. All requests will have a charge of (fifteen $0.15) per page, Cd's ($5.00) and all Medical records ($25.00). All payments are due before releasing or requesting any patient information.
7. **Only the patient will be responsible** to follow-up the status of the releasing process by calling the office.
8. **This document will not be valid after 30 business days from the day of the request.**

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