JOANNE CRENSHAW, M.D., P.C.
21135 Whitfield Place, #102
Potomac Falls, VA 20165

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

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

Organization providing the information

_____
_____
_____

Organization receiving the information
Joanne Crenshaw, M.D., P.C.
Phone: 703-766-6165
Fax: 703-345-9356

Specific description of the information, including date(s) of healthcare, to be disclosed:

_____
_____
_____

The purpose of the requested use or disclosure is to facilitate medical decision making and treatment options for the patient. Dr. Crenshaw will not receive any financial or other kind of compensation in exchange for using or disclosing the health information described above.

_____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_____

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it. Initials:_____

I understand that this authorization will expire on_____/_____/2_____ Initials:_____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. Initials_____

_____ _____
Signature of patient (or patient's representative) **Date**
(This form MUST be completed before signing)

Printed name of patient's representative:_____
Relationship to the patient:_____