

Ryan Crenshaw, M.D.
21135 Whitfield Place, Unit 102
Sterling, 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: _____

Organization providing the information

Organization receiving the information

Office of Ryan Crenshaw, M.D.

21135 Whitfield Place, Unit 102

Sterling, VA 20165

Phone: _____

Phone: 703-444-4799

Fax: _____

Fax: 703-444-4985

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

The purpose of the request 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 for using or disclosing the health information described.

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

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.

I understand that this authorization will expire on ____/____/2____

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.

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

Date

Printed name of patient's representative: _____

Relationship to the patient: _____