

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HEALTH CARE INFORMATION**

Patient name:		Date of birth:
Street Address:		
City	State	Zip

This authorizes MID-ATLANTIC FAMILY MEDICINE to request and receive from the Virginia Department of Health Professionals any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professionals to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to redisclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient signature:	Date:
Guardian signature:	Date:

Note: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.