O&O Alpan, LLC

www.oandoalpan.com

11212 Waples Mill Road, Suite 100, Fairfax, VA 22030
121 Congressional Lane, Suite 320, Rockville, MD 20852
7229 Forest Avenue, Suite 109, Richmond, VA 23226

Phone: 571-308-1900
Fax: 571-308-1919
info@oandoalpan.com

Name of Patient: _____

Date of Birth: _____ **Phone Number:** _____

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED. THE INFORMATION BEING DISCLOSED MAY INCLUDE HIV/AIDS, DRUG/ALCOHOL ABUSE & MENTAL HEALTH DATA. ONLY INFORMATION THAT IS CREATED ON OR PRIOR TO THE DATE OF THE SIGNATURE BELOW WILL BE RELEASED.

I HEREBY AUTHORIZE O&O ALPAN, LLC.

A. **RELEASE TO** OR B. **RECEIVE FROM**
(Circle One)

_____
(Name of Authorized Person, Agency, Institution, or Other)

_____
(Address – Street, City, State, Zip Code)

Reason for Request: _____

Type of Information to be released consists of:

Discharge Date(s)
Discharge Summary (or Summaries)
History & Physical Operative Report
Outpatient Visit Date(s)
Diagnostic Test(s)
Other (Please Specify) _____

Indicate Type of Test & Date _____

I, _____, hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated and herein.

_____
Signature of Patient or Representative Date

Relationship if signed by other than Patient _____

Note to recipient of information: The information that has been disclosed to you from the records may prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to: Medical Records Department, O&O Alpan LLC, 11212 Waples Mill Rd., Ste. 100, Fairfax, VA 22030. If not previous revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at the above facility. Neither our treatment nor your payment is conditioned upon your signature on this form.