The GW Medical Faculty Associates

Authorization for Disclosure or Access of Protected Health Information

Please use this form when authorizing someone to access your Medical Records

PATIENT NAME: _____ DOB: _____ MRN: N/A

ADDRESS: _____

_____ PHONE NUMBER: _____

I, _____ (print name**) hereby authorize the GW Medical Faculty Associates (the "MFA") to disclose Protected Health Information pertaining to the care and treatment of the patient listed above. I authorize the disclosure of the following information from the Medical Record:**

The persons or entity whom I authorize this information to be disclosed to:

Name: Bermuda Short Handed Return Race Coordinators Relationship to Patient: Race Coordinators

Address: 37 West 44th Street, New York, NY 10036 USA

Telephone: +1 (212) 382-1000 Fax (When Applicable): +1 (212) 391-6368

The purpose for which this information may be disclosed (*Check one*)**:**

☐ At the request of the individual listed above ☐ Legal ☐ Insurance

☐ Other (specify purpose): _____

I authorize the MFA to disclose the following information to the persons listed above. (*Check all that apply & note the dates of treatment*)**:**

☐ Records specific to a Provider or Location seen (Specify): _____

☐ Entire Medical Record

☐ Limited to the following dates of treatment: From: _____ To: _____

☐ Laboratory/Pathology Reports

☐ Radiology Reports (e.g., X-ray, CT, MRI) ☐ Radiology Images (e.g., X-ray, CT, MRI)

☐ Billing information (e.g., billing statements, balance due)

☐ Other _____

If I do not revoke this authorization it will remain in effect until (specify date or event)**: _____**
If I do not provide an expiration date, this Authorization will expire in 1 year of the date of this authorization.

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I, _____ (print name) acknowledge the following statements:

I understand that signing this form is voluntary and I have the right to refuse to sign it. However, if I refuse to sign the GW Medical Faculty Associates, will not release my medical records except as authorized under HIPAA. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned based upon my authorization of this disclosure.

I understand that I may revoke this Authorization at any time by providing a written notice of revocation to:
GW Medical Faculty Associates Attn: HIM Department: 3811 N. Fairfax Drive, Suite 1000 Arlington VA, 22203

I understand that the revocation will not apply to information that has already been released in response to this authorization.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be re-disclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

_____ _____

Signature of Patient or Personal Representative authorized by law* **Date**

_____ _____

If personal representative, print name **Relationship to patient**

**Signers other than the patient must present legal documentation that authorizes them to act as the Personal Representative.*

Please Mail or Fax this completed Authorization form to the GW Medical Faculty Associates HIM Department			
	Mailing Address	**In Person Address**	
Patients	GW Medical Faculty Associates Attn: HIM Department 2150 Pennsylvania Ave, NW Suite G-206 Washington, DC 20037	GW Medical Faculty Associates Attn: HIM Department 2150 Pennsylvania Ave, NW Suite G-206 Washington, DC 20037	Fax: 202.741.2405
Physician/Insurance /Law Firm or Other Third Party	GW Medical Faculty Associates Attn: HIM Department 2150 Pennsylvania Ave, NW Suite G-206 Washington, DC 20037	Please Mail or Fax this completed Authorization form to the GW Medical Faculty Associates HIM Department	Fax: 202.741.2431