

LAURAL MOYLAN, MD, PC
3130 CHAPARRAL DR, SUITE 202
ROANOKE, VA 24018-4369

Office 540-776-6800

FAX 540-776-2919 (will be functional after office closure)

email after office closure: dilaunamoylanrecordrequestonly@gmail.com

RELEASE OF MEDICAL RECORD REQUEST

Records released from:

LAURAL MOYLAN, MD, PC

3130 CHAPARRAL DR, SUITE 202

ROANOKE, VA 24018-4369

Records released to:

FAX

PHONE

The reason for the request of record release is: Continuity of Care, Practice Closing

I, the undersigned, hereby authorize release of the following information:

Pertinent medical records including information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS, or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted by the health care facility in lieu of the original.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire 15 months from the date of the signature.

Fax copies of my record do not incur a cost. If I request a paper copy, I agree to pay for the cost of providing that copy to the party indicated above, per state law.

PATIENT INFORMATION:

NAME

Date of Birth Phone Number

Address

If applicable, date of new patient appointment with new provider

PATIENT SIGNATURE DATE

WITNESS SIGNATURE DATE