BATH COMMUNITY PHYSICIANS GROUP

REQUEST OF INFORMATION

Bath Physicians Group
713 S Monroe Ave
Covington, VA 24426
Phone: 540-962-1122
Fax: 540-962-7881

Patient Name: _____ **Date Of Birth:** _____

I authorize, Bath Community Physicians Group to:

Send / Receive MY RECORDS To / From

Facility: _____ **Physician:** _____

Reasons for Records: CONTINUATION OF CARE **Patient Social/Identifying # XXX-XX-**_____

____ **This consent is subject to revocation by the undersigned at any time. This request Terminates six months from the Date of consent, without written revocation.**

____ **I hereby consent to the release of any and all records containing alcohol and /or drug abuse and /or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without specific consent, except in accordance with a court order.**

____ **I further understand that I have a right to a copy of this authorization upon initial request**

Copy request: ☐ **Yes/** ☐ **No** **Copy Received:** ____ **Yes/**☐**No**

Information Requested:

- **ER NOTE**
- **HISTORY & PHYSICAL**
- **OPERATIVE REPORTS**
- **LAB/TEST RESULTS**
- **IMAGINE REPORTS**
- **DISHCHARGE SUMMARY**
- **COMPLETE MEDICAL RECORD**
- **OTHER** _____

Signed: _____ **Date:** _____
(Patient, Parent or Legal Guardian)

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Fax:** _____

Witness: _____ **Date:** _____