WILLIAM EARL FOX, M.D.

675 Peter Jefferson Parkway

Suite 335

Charlottesville, VA 22911

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

By signing this form, I request and authorize Dr. William E. Fox, MD to release or disclose the protected health information below to:

Name (Doctor, family member, spouse, healthcare facility-do not list self):

_____

Address of person listed above:

_____

Office Phone: _____ Cell Phone: _____ Home Phone: _____

Fax Number: _____ Email Address: _____

The protected health information is being released or disclosed for the purpose of:

___coordination of care ___transfer of care ___insurance

___legal ___communication with family

The authorization applies to:

___written clinical record ___verbal clinical assessment ___specifics as detailed in the following:

_____

Signature for authorization of release of information:

Patient Legal Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____