



Jeffrey P. Haggquist, DO, PLLC
Flexibility, Sports & Rehabilitation Clinic
5506 Connecticut Avenue NW, Suite 27
Washington, DC 20015
Tel: 202-244-8222 Fax: 202-244-7432
www.quistmd.com

Authorization for Release of Information

Patient Name Date of Birth Date

A. I, _____ hereby authorize Jeffrey P. Haggquist, DO PLLC/The Flexibility, Sports & Rehabilitation Clinic to furnish information in its possession relative to my diagnosis, treatment or account status to other treating physicians, other treating healthcare providers and healthcare institutions who I specify, and to my insurance carrier(s) and their agents.

B. Further, I understand my mental health/psychological information cannot be disclosed without my specific authorization.

I, _____ do/ do not (circle only one) authorize Jeffrey P. Haggquist, DO, PLLC / The Flexibility, Sports & Rehabilitation Clinic to disclose mental health/psychological information in its possession relative to my diagnosis and treatment to other treating physicians, other treating healthcare providers and healthcare institutions who I specify, and to my insurance carrier(s) and their agents.

The unauthorized disclosure of mental health information violates the provisions of the Commonwealth of Virginia – Code of Virginia § 32.1-127.1:03 - Health Records Privacy. Disclosure may only be made pursuant to valid authorization by the client or as approved by the Laws and Regulations of the State.

C. I understand if I refuse to sign this consent, the information will no be released. In addition, I am aware any and all consents may be revoked by me when the revocation is submitted in writing. Any such revocation shall have no effect on disclosures made prior to the date the revocation is received. The consent is valid for ninety (90) days from the date signed, except that copies of ongoing medical care records may be release to my named physician(s) unless consent is withdrawn in writing.

Signature (Patient/Client Legal Guardian) Date Relationship

Witness Date

The witness must be able to confirm the identity of the person in order to authorize the disclosure of information.

RECORDS TO BE SENT TO:

Name: _____ Name: _____

Address: _____ Address: _____

Phone No. _____ Phone No. _____

Fax No. _____ Fax No. _____

List additional names on the back of this page