PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

UNIVERSITY OF VIRGINIA HEALTH SYSTEM

FORM # 030105 CAT: 15 - PATIENT DATA (REV. 03/11) To reorder, log onto http://www.virginia.edu/uvaprint 1 OF 1

1500000

University of Virginia Health System

Release of Information, Health Information Services

PO Box 800476, Charlottesville, VA 22908

Phone 434-924-5136 Fax 434-924-2432

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print patient’s full name) Birth date (Mo/Day/Yr)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street address) Phone (Home or Cell)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, state, zip code) Phone (Work)

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize University of Virginia Health System, to release:

(patient or patient name)

\_\_\_\_\_\_\_\_\_\_\_ Discharge Summary [date(s)] \_\_\_\_\_\_\_\_\_\_\_ History & Physical [date(s)] \_\_\_\_\_\_\_\_\_\_\_ Operative Report [date(s)]

\_\_\_\_\_\_\_\_\_\_\_ Pathology Reports [date(s)] \_\_\_\_\_\_\_\_\_\_\_ Immunization Record \_\_\_\_\_\_\_\_\_\_\_ X-Ray and Imaging Report [date(s)]

\_\_\_\_\_\_\_\_\_\_\_ Laboratory Results [date(s)] \_\_\_\_\_\_\_\_\_\_\_ Emergency Room Record [date(s)] \_\_\_\_\_\_\_\_\_\_\_ Entire Record [date(s)]

\_\_\_\_\_\_\_\_\_\_\_ Consultation Report [date(s)] and Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ Clinic Notes [date(s)] and Doctor’s Name:

\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: (For Patient Assistance Program) \_\_\_\_\_ Allergy Inform \_\_\_\_\_ Diagnosis \_\_\_\_\_ Financial \_\_\_\_\_ Insurance \_\_\_\_\_

Medication

If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions:

INFORMATION RELEASE TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME (Physician, hospital, agency, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, state, zip

Purpose of Disclosure: \_\_\_\_\_ Personal \_\_\_\_\_ Continuing Care \_\_\_\_\_ Insurance \_\_\_\_\_ Attorney

\_\_\_\_\_ Workers Comp \_\_\_\_\_ Other/state purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the University of Virginia Health System may not condition its providing of health care on whether copies to individuals or organizations as I request, I understand there is a fee of $.50 per page for pages 1-50, $.25 per page for pages 51+, plus actual postage if mailed. Fees are waived when copies are requested by other health care providers agencies/facilities for continuing care. All other requestors are charged as state and federal laws allow.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative of patient Date

If signed by Legal Representative, Describe Authority to act on Patients Behalf

If Translated: INTERPRETER ATTESTATION (when applicable)

Translation has been provided by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recibi una copie traducida de este documento. Patient Initials \_\_\_\_\_\_\_\_\_\_\_

(I received a translated copy of this document) Form # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_