UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1500000

PLACE LABEL HERE.

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

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 # _____