UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1500000

PLACE LABEL HERE.

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

University of Virginia – Health Information Services
PO Box 800476, Charlottesville, VA 22908
Phone 434-924-5136 Fax 434-924-2432

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For UVA Health Information Services Release Purposes Only

_____ _____
(Patient's full name or Legal Guardian) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Phone (Home or Cell)

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

Fees are waived when copies are requested by other health care provider's agencies/facilities for continuing care or by patients for personal use. All other requestors are charged as state and federal laws allow. **Photo ID** is required.

I _____, hereby authorize **University of Virginia Health System,** to release**:**
(patient, legal guardian)

COPIES OF MEDICAL RECORDS:

☐ PERTINENT ELEMENTS ONLY (MOST RECENT DISCHARGE SUMMARY, HISTORY & PHYSICAL, AND OPERATIVE RECORD)

☐ OTHER ELEMENTS
- ☐ Immunization Record
- ☐ Clinic Notes [date(s)] and Doctor's Name: _____
- ☐ Other: _____
- ☐ Pharmacy: (For Patient Assistance Program) ☐ Allergy Inform ☐ Diagnosis ☐ Financial ☐ Insurance ☐ Medication
- ☐ X-Ray and Imaging Report [date(s)] _____
- ☐ X-Ray/Imaging Film/CD [date(s)] _____
- ☐ Emergency Room Record [date(s)]_____

MEDIA TYPE:

☐ MyChart ☐ CD ☐ Paper

I understand that I am giving my permission to release 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 ☐ Insurance (fee) ☐ Attorney (fee) ☐ Workers Comp

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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.

_____ _____
Signature of Patient or Legal Representative of Patient **Date**

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

_____ _____
Patient's Authorized Representative **Date**