



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. 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 Doctors Name
Other:
X-Ray and Imaging Report [date(s)]
X-Ray/Imaging Film/CD [date(s)]
To include Dental Imaging [date(s)]
Emergency Room Record [date(s)]
Pharmacy: (For Patient Assistance Program) Allergy Inform Diagnosis Financial Insurance Medication

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
Self (information noted above)

Purpose of Disclosure: Personal Insurance Attorney Workers Comp

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 are released 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