UVA Health

1500000

PLACE LABEL HERE.

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

# AUTHORIZATION FOR SHARING OF INFORMATION: PATIENT TO PATIENT

☐UVA Health Medical Center
PO Box 800476
Charlottesville, Va. 22908
434-924-5136
434-924-2432 (Fax)
CLHIMDCT@hscmail.mcc.virginia.edu

☐UVA Health Prince William Medical Center
8700 Sudley Rd
Manassas, Va. 20110
703-369-8297
703-369-8285 (Fax)
uvachrecordsrequest@uvahealth.org

☐UVA Health Haymarket Medical Center
15225 Heathcote Boulevard
Haymarket, Va. 20169
540-369-8297
703-369-8285 (Fax)
uvachrecordsrequest@uvahealth.org

☐UVA Health Culpeper Medical Center
501 Sunset Lane
Culpeper, Va. 22701
540-829-4386
540-829-4326 (Fax)
ROICulpeper@uvahealth.org

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

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

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

I, _____

give permission to my provider,_____,

to share my diagnosis, treatment, and contact information with another patient wishing to obtain my peer patient perspective on my experience with the medical condition that we have in common. 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 or shared prior to notification of cancellation. I understand that my medical care is not dependent upon my signing this authorization. I understand that the information disclosed may be subject to re-disclosure by the person receiving it, and would then no longer be protected by federal privacy regulations.

_____ _____
**Signature of Patient** **Date**

_____
**Printed Name of Patient**