UVA Health

150000

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

Authorization for UVA Health Information Release of Medical Information

NOT to be utilized to obtain records from other facilities, for verbal conversation or outside of UVA Health Information

To request substance use disorder records subject to 42 CFR Part 2, you must complete the Disclosure of Confidential Substance Use Disorder (SUD) Patient Health Records form.

*For Community Health (CH) medical group clinics, please select the closest CH facility

☐University Hospital
PO Box 800476
Charlottesville, Va. 22908
434-924-5136
434-924-2432 (Fax)
CLHIMDCT@hscmail.mcc.virginia.edu

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

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

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

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

_____ _____
(Street address, City, State, and Zip) Phone (Home or Cell)

Any and all Previous names/aliases _____

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 **UVA Health Information**, to release:
(Patient, legal guardian)

COPIES OF MEDICAL RECORDS:

☐ PERTINENT ELEMENTS ONLY (MOST RECENT DISCHARGE SUMMARY, HISTORY&PHYSICAL, OPERATIVE RECORD & IMMUNIZATIONS)
☐ CLINIC NOTES (DATES) _____
☐ X-RAY/IMAGING FILM/CD (DATES) _____
☐ X-RAY AND IMAGING REPORT (DATES) _____
☐ EMERGENCY DEPARTMENT REPORT (DATES) _____
☐ OTHER/PHOTOGRAPHS _____

MEDIA TYPE: ☐MyChart ☐CD ☐Paper ☐Email (with encryption for security purposes)

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, and 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 UVA Health 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 e 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**