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 ACCESS BY HOSPITAL EDUCATION

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

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

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

I, _____ ,

give permission for the Hospital Education Program (HEP) to access my child's medical record. By giving this authorization, I understand the HEP may exchange information with my child's local school or community agency. 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.

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

_____
Printed Name of Parent or Legal Representative of Patient