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 SHARING OF INFORMATION: PATIENT TO PATIENT

(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 _____