UVA Health

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 UVA Health Information Services Release of Medical Information

NOT **to be utilized to obtain records from other facilities or outside of UVA Health Information Services Dept.**

(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 _____ (patient, legal guardian), hereby authorize **University of Virginia Health System,** to release**:**

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)] _____

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** _____