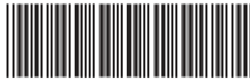

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

150000

Authorization for UVA Health Information Management (HIM) - Release of Medical Information

Patient Information:

____ Patient's Full Name

______________________ Birth Date (Month/Date/Year)

____ Street Address, City, State, and Zip

______________________ Contact Telephone Number

Any Previous Names or Aliases? ____

Who Should Receive the Information and In What Format:

☐ Self (information noted above)

____ Name (Physician, Hospital, Agency, etc.)

____ Street address, City, State, and Zip Code

____ Phone Number/Fax Number/Email

Format: ☐MyChart ☐CD ☐Paper ☐E-mail

Purpose for Disclosure:

☐ Personal
☐ Continuation of Care
☐ Insurance
☐ Attorney/Legal
☐ Worker's Compensation/Disability
☐ Other: ________________________________

UVA Health Locations Where Patient Has Been Treated/Seen:

☐ University Hospital - Charlottesville
☐ Community Health – Prince William
☐ Community Health - Haymarket
☐ Community Health - Culpeper
☐ Piedmont Family Practice
☐ Other: ________________________________

Information to be Released:

Dates of Services From: ______________________ **To:** ______________________

☐ Pertinent Elements (Most recent Discharge Summary, History & Physical, Operative Report, & Immunizations)
☐ Clinic Notes
☐ X-Ray/Imaging Film
☐ X-Ray/Imaging Reports
☐ Photographs
☐ Other: ____

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:

____

Note the following:

- Contact 434-924-5136 with any questions
- Submit form to PO Box 800476 Charlottesville, VA 22908-0476, 434-924-2432 (fax) or CLHIMDCT@hscmail.mcc.virginia.edu
- This form shall not be used for any purposes outside of HIM (e.g. verbal conversations, obtaining records from another facility, etc.)
- Fees are waived when for continuation of care purposes or by patients. All other requestors are charged as state and federal laws allow.
- Photo ID is required. If the requestor is not the patient, legal documentation may be required.
- 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
- The 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 of Patient**

______________________ **Date**

______________________ **Relationship if not patient***

☐ I attest that the patient lacks capacity and I am their legal representative