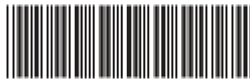

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IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Authorization for UVA Health Information Management (HIM) - Release of Medical Information Disclosure of Confidential Substance Use Disorder (SUD) Patient Health Records

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? ____

Purpose for Disclosure:

- ☐ Personal
- ☐ Continuation of Care
- ☐ Insurance/Payor
- ☐ Attorney/Legal/Probation Officer
- ☐ Other: ____________________________________

Who Should Receive the Information and In What Format:

- ☐ Self (information noted above)
- ☐ Individual(s): ____
- ☐ Treating Provider(s): ____
- ☐ Payor(s): ____
- ☐ Other: ____

____
Street address, City, State, and Zip Code

____
Phone Number/Fax Number/Email

Format: ☐MyChart ☐CD ☐Paper

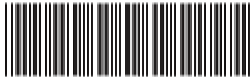
UVA Health Locations Where Patient Has Been Treated/Seen for Substance Use Disorder:

- ☐ University Hospital - Charlottesville
- ☐ Community Health – Prince William
- ☐ Piedmont Family Practice

Information to be Released Related to Substance Use Disorder:

Dates of Services From: ___________________________ To: ___________________________

- ☐Admission to the Program
- ☐Assessment and Diagnosis
- ☐Compliance with Treatment Recommendations & Referrals
- ☐Diagnostic Lab Results
- ☐Financial Documentation
- ☐Other: ____________________________________
- ☐Program Participation
- ☐Progress Towards Accomplishing Treatment
- ☐Plan Goals & Objectives
- ☐Results of Drug Screen and Breathalyzer Tests
- ☐Treatment Plan Goals & Objectives



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

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@uvahealth.org
- This form shall not be used for any purposes outside of HIM (e.g. verbal conversations, obtaining records from another facility, etc.)
- I understand that the disclosure will be limited to the extent necessary to carry out the purpose identified above
- I understand that if I have authorized disclosure to “my treating providers”, listed on page 1, I may request at any time that UVA Health provide me with a list of all said disclosures in the preceding two years, including the name of the individuals/entities to whom a disclosure was made, the date of disclosures, and a brief description of the identifying information disclosed. I understand my request must be made in writing, and UVA Health will have 30 days to respond.
- I understand that my consent contained herein is subject to revocation at any time except to the extent that UVA Health or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payor(s) (i.e. my insurance company).
- I understand that I have the right to revoke this authorization at any time prior to records being released. My revocation will not be effective until delivered in writing to Health Information Management. A copy of my revocation shall be maintained.
- Fees are waived when for continuation of care purposes or requested 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.
- The authorization is valid for 12 months from the date of signature unless I indicate an earlier date here: ______________

____ _______________________
Signature of Patient or Legal Representative of Patient **Date**

______________________________ ☐ I attest that the patient lacks capacity and I am their legal representative
Relationship if not patient*

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.