



DATE: _____

I hereby authorize

**Virginia Hospital Center
Health Information Management
1701 N. George Mason Drive
Arlington, Virginia 22205
PHONE: 703-558-6116 FAX: 703-558-6979**

to release to the following physician all medical records, including but not limited to the treatment or evaluation of alcohol or drug use, HIV/AIDS and/or psychiatric conditions:

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

_____ I do _____ I do NOT authorize these records to be faxed.

Records will only be faxed for immediate direct patient care (patient in office/facility receiving care)

Patient: _____

Date of birth: _____

Date of service: _____

RECORD TYPE	√	RECORD TYPE	√
ABSTRACT (dictations/lab/rad)		Laboratory results	
Emergency report		Radiology report	
Discharge summary		Pathology report	
History & Physical		EKG/ECG/EEG	
Operative report		Progress notes	
Consultations			

Date and time of appointment: _____

- ~ I understand drug, psychiatric and/or HIV/AIDS treatment records will not be faxed.
- ~ I understand this authorization will expire in 12 months or specified date _____.
- ~ I understand I may revoke this authorization at any time in writing. This cancelation will not apply to information already released.

Patient's signature: _____

Date of signature: _____

Release of Information Department use only:

ABS ___ HP ___ RAD ___ other ___ ROI Specialist _____
ER ___ Path ___ OP ___ Date: _____
DS ___ Lab ___ EKG ___ No. Pages: _____