Authorization for Release of Medical Record Information

Virginia Hospital Center

Health Information Management Department
1701 North George Mason Drive
Arlington, VA 22205
Phone: 703-558-6116 FAX: 703-558-6979

Medical Record Number_____
Date/Time Doctor's Appointment_____
Doctor's Phone/Fax Number_____

(1)_____(2)_____
Patient's Name at Time of Treatment **Date of Birth**

(3)_____(4)_____
Street Address **Home Phone Number**

_____ _____
City **State** **Zip Code** **Work/Cell Phone**

(5)The undersigned hereby authorizes and requests Virginia Hospital Center to provide access to my medical record for the **purpose of**: □**Continued Medical Care** □ **Personal** □ **Legal** □ **Other:**_____
Provide records by **means of**: □ **Mail** □ **Pick-Up** □ **Fax* - Records will only be faxed for immediate direct patient care to physician offices, hospitals, or other treatment facilities.(Patient is in office/facility receiving treatment) Items listed in # 9 and #10 will not be faxed.** ****Charges may apply for record copies****

(6)_____
Identity of any duly authorized representative (name of person to send your records to, **please do not put "self" or N/A**)

_____
Street Address **City** **State** **Zip Code**

The foregoing is subject to such limitations as indicated below:
(7) Covering records for the period from: _____ to _____. Date range is acceptable.
Date **Date**

(8) Confined to the following specified information: Please check what information is needed.

□ Discharge Summary Reports
□ History and Physical Report
□ Lab Report
□ X-ray, MRI, Ultrasound, and/or CT scan Reports
□ Emergency Room Record
□ Outpatient/Clinic Record
□ Physician's Orders
□ EKG Findings
□ Progress Notes
□ Operative Reports and Pathology Reports
□ Consultations
□ Other_____
□ Abstract (all dictated reports/Lab/Rad/EKG)

** Fee for copies are $ .50/page up to 50 pages + $ .25/page starting with 51st page . ~Nursing notes available upon request with fees applied~
Virginia Hospital Center has contracted with HEALTHPORT to process our billing for copies of medical records. Billing questions? 1-800-464-0035.

(9) IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2)
I hereby consent to the release of any and all records for the treatment of alcohol or drug use.

(10) I hereby authorize Virginia Hospital Center to release to the above named source the following information for the period(s) identified above: All medical records or other information regarding my treatment, including treatment or evaluation for psychiatric and/or HIV/AIDS conditions.

(11) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition this authorization will expire 1 year from the date signed.

(12) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director/Privacy Officer at 703-558-6972. Virginia Hospital Center is not responsible for any re-disclosure of the information provided.

(13) I understand that there may be a charge for searching, handling, maintaining, reviewing, and preparing copies in accordance with 8.01-413 of the Code of Virginia.

(14)_____ (15)_____/_____
Date Signature of Patient Printed Name of Patient

(16)_____(17)_____/_____
Witness Signature of Legal Representative Printed Name of Legal Representative