VIRGINIA HOSPITAL CENTER

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: _____