

Health Information Management Dept.
 1701 North George Mason Drive
 Arlington, VA 22205
 Phone: 703-558-6117 FAX: 703-558-6979

Medical Record Number _____
 Doctor's Appt Date/Time _____
 Doctor's Phone/Fax Number _____

(1) Patient's Name at Time of Treatment:	(2) Date of Birth:	(3) Phone number:
(5) Address:	City:	State:
		Zip Code:

(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

Provide records by means of: Mail Pick-Up Email Fax* Format: Paper Copy Electronic Media (USB or CD)
 Encrypted Email Unencrypted Email

*NOTE: Records will only be faxed for immediate direct patient care to physician offices (not affiliated with Virginia Hospital Center), hospitals, or other treatment facilities. (Patient is in office/facility receiving treatment) Items listed in # 9 and #10 will not be faxed.
 NOTE: If the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). We are not responsible for unauthorized access to the Protected Health Information (PHI) contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (if email checked above. Please print legibly): _____

(6) _____
 Identity of Person or Organization to send your records to. Fill in completely even if records are returning to you.

Street Address City State Zip Code

The foregoing is subject to such limitations as indicated below:

(7) Covering records for the period from: _____ to _____.

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

<input type="checkbox"/> Discharge Summary Reports	<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> History and Physical Report	<input type="checkbox"/> Outpatient/Clinic Record	<input type="checkbox"/> Nurse's Notes
<input type="checkbox"/> Lab Report	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Operative Reports and Pathology Reports
<input type="checkbox"/> X-ray, MRI, Ultrasound, and/or CT scan Reports	<input type="checkbox"/> EKG Findings	<input type="checkbox"/> Consultations
<input type="checkbox"/> Physician access to all above information via computer if available		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Abstract (all dictated reports/Labs/Rad/EKG)		

**** Fee for copies are \$.50/page up to 50 pages + \$.25/page starting with 51st page.**
**** Any records not available in MyVHC Patient Portal will be available at your request for a fee.**

(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 and Relationship of Legal Representative




 VIRGINIA HOSPITAL
 CENTER
**Authorization for Release of
 Medical Record Information**

Patient Label