Virginia Hospital Center Health System
Health Information Management Dept.
1701 North George Mason Drive, Arlington, VA 22205
Phone: 703-558-6116 FAX: 703-558-8699

WHERE WERE YOU SEEN?

☐ Hospital
☐ VHC Physician Group_____
Re: (Physician Name)_____

(1) **Patient's Name at Time of Treatment:**	(2) **Date of Birth:**		(3) **Phone number:**
(4) **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** ☐ **Virginia Code §32.1-127**

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 _____.
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
☐ Physician access to all above information via computer if available
☐ Abstract (all dictated reports/Labs/Rad/EKG)
☐ Emergency Room Record
☐ Outpatient/Clinic Record
☐ Physician's Orders
☐ EKG Findings
☐ Progress Notes
☐ Nurse's Notes
☐ Operative Reports and Pathology Reports
☐ Consultations
☐ Other:

**** 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) The following types of information **will be released unless** you place your initials in the space provided next to the information that you do not want to be released:

____ Alcohol/Drug Abuse Treatment ____ Genetic Testing or Results ____ Mental Health Treatment (Other than Psychotherapy Notes)
____ HIV/AIDS Testing or Results ____ Sexually Transmitted Disease Treatment

(10) 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.

(11) 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.

(12) 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.

(13) _____ (14) _____/_____
Date **Signature of Patient** **Printed Name of Patient**

(15) _____ (16) _____/_____
Date **Signature of Legal Representative** **Printed Name and Relationship of Legal Representative**

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VIRGINIA HOSPITAL CENTER
Health System

Authorization for Release of Medical Record Information

121917-8400-08302019

Patient Label