

**Guidelines For Requesting
Authorization to Release Confidential Healthcare Information**

To request a copy of your medical records, you will need to complete the form, *Authorization To Release Confidential Healthcare Information*. Please read the entire authorization form to understand all your rights. All of the following items **must** be answered completely:

Complete the patient's name, complete address, phone numbers, date of birth and social security number.
If you know your medical record number, please list it under MRN.

2. Identify the person or organization authorized by you to release your medical record information (example: UVA Health System).
3. Check appropriate boxes for the information you are requesting to be released. Include the doctor's name and the dates of the requested information.
4. Please read statement. If there is information that you do not want to be released to the person or organization you have indicated, please list on the line provided. Otherwise, leave blank.
5. A. Identify the person or organization to receive your medical record information (example: Dr. John Brown)
If the information is for yourself you will need to complete with your name and address.
B. Indicate the purpose of requesting the release of your medical record. If it is for your own personal use, write "For Personal Use".
6. Please read statement. The authorization will be invalid 6 months from the date of your signature, unless you indicate a different date.
7. Please read statement.
8. Please read statement
9. Please note that UVa Health System charges for copies of health information in compliance with Virginia statutes as follows:
 - Patients are charged a copying fee of \$.50 per page.
 - Copies to other physicians and healthcare facilities are provided free of charge.
 - All other requestors are charged as state and federal laws allow.
10. Please read statement. Checking the box allows the disclosed information to be exchanged between the individuals/organizations you have listed on this request form for the purpose you have described in section 5.

Signature for Authorization to Release Confidential Healthcare Information

- A. Your signature or your legal representative's signature.
- B. Date of signature.
- C. If signed by your legal representative, a description of the representative's authority to act in your behalf.

The completed request should be directed to Release of Information at the following address:

**UVa Health System
Health Information Services, Release of Information
P.O. Box 800476
Charlottesville, Virginia 22908**

Please call Release of Information with any questions at (434) 924-5136.