



PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

University of Virginia Health Systems
Release of Information, Health Information Services
PO Box 800476, Charlottesville, VA 22908
Phone 434-924-5136 Fax 434-924-2432

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This form should not be used to request records received from a source other than UVA Health System.

(Print patient's full name)

Birth date (Mo/Day/Yr)

(Street address)

Phone (Home or Cell)

(City, state, zip code)

Phone (Work)

At the request of the individual, I _____, do hereby authorize **University of Virginia Health Systems** to release:
(patient or patient name)

- Most recent Discharge Summary [date(s)]
- Most recent History & Physical [date(s)]
- Immunization Record
- Entire Record [date(s)]
- Pathology Reports [date(s)] _____
- Operative Report [date(s)] _____
- Emergency Room Record [date(s)] _____
- X-Ray and Imaging Report [date(s)] _____
- Laboratory Results [date(s)] _____

Consultation Report [date(s)] and Doctors Name: _____

Clinic Notes [date(s)] and Doctor Name: _____

Other: _____

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

NAME (Physician, hospital, agency, etc.) _____

Street address _____

City, state, zip _____

PURPOSE OF DISCLOSURE:

- REFERRAL TO SPECIALIST
- LEGAL INVESTIGATION
- INSURANCE
- DISABILITY DETERMINATION
- WORKERS COMP
- PERSONAL

OTHER (SPECIFY) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Patient or Legal Representative of patient

Date

If signed by Legal Representative, Describe Authority to act on Patients Behalf

If Translated: INTERPRETER ATTESTATION (when applicable)

Translation has been provided by: _____ Date/Time: _____

Recibi una copie traducida de este documento. Patient Initials _____

(I received a translated copy of this document) Form # _____