



1500000

PLACE LABEL HERE.

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

University of Virginia Health System  
Release of Information,  
Health Information Services  
P.O. Box 800476 • Charlottesville, VA 22908-0476  
Telephone: (434) 924-5136

**AUTHORIZATION TO RELEASE  
CONFIDENTIAL HEALTHCARE INFORMATION**

**DO NOT RELEASE INFORMATION IF THIS AUTHORIZATION IS NOT COMPLETELY FILLED OUT—  
ALL BLANKS MUST BE COMPLETED**

1. A Patient Name \_\_\_\_\_

B MRN (For UVA use only) \_\_\_\_\_ C Date of Birth \_\_\_\_\_

D Address \_\_\_\_\_

E City \_\_\_\_\_ F State \_\_\_\_\_ G Zip Code \_\_\_\_\_

H Home Telephone Number \_\_\_\_\_ I Work Telephone Number \_\_\_\_\_

2. I authorize the use or disclosure of the above named individual's health information as described below:

3. The following individual or organization is authorized to disclose my medical information  
(e.g., UVA Health System):

A Name \_\_\_\_\_

B Address \_\_\_\_\_

4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

A  Most recent discharge summary

B  Most recent History & Physical

C  Immunization Record

D  Consultation report from (doctor's name) \_\_\_\_\_

E  Laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

F  X-ray and imaging reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

G  Entire record

H  Operative Report from (date) \_\_\_\_\_

I  Emergency Room Record from (date) \_\_\_\_\_

J  Clinic notes from (date) \_\_\_\_\_

K  Other (must specify) \_\_\_\_\_

5. If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions:

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6. This information may be disclosed to the following individual or organization:

Name \_\_\_\_\_

Address \_\_\_\_\_

For the purpose of \_\_\_\_\_

(If the patient or representative is requesting this release of information, s/he may fill in this blank with "at the request of the individual")

7. I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in six (6) months from the date signed, unless an expiration date, event or condition is specified as follows:

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8. I understand that the information disclosed to the above individual or organization may be redisclosed and not be protected by the federal Privacy Rule. If I have questions about disclosure of my health information, I may contact the Release of Information Office of Health Information Services.

9. I understand that the UVA Health System cannot condition its providing of health care on whether or not I sign this authorization, unless I am requesting care specifically for it to be disclosed under this authorization (for example, a physical for school enrollment).

10. In the event UVA Health System provides copies to individuals or organizations as I request, I understand there is a fee of \$.50 per page for the first 50 pages and \$.25 per page for pages greater than 50. Fees are waived when copies are sent to other health care providers/agencies/facilities. All other requestors are charged as state and federal laws allow.

11. If I check the following box, the individuals or organizations named in sections 3 and 6 above may each disclose the information described in section 3 to each other, for the purpose described in section 5.

12. The Medical Center uses social security numbers for identification and verification; for example, to provide the right medical record when two patients have the same name. Providing a social security number is voluntary but failing to do so may delay the requested service.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
IF SIGNED BY LEGAL REPRESENTATIVE, DESCRIBE AUTHORITY TO ACT ON PATIENT'S BEHALF

If Translated: INTERPRETER ATTESTATION (when applicable)

Translation has been provided by: \_\_\_\_\_ Date/Time \_\_\_\_\_  
SIGNATURE OF INTERPRETER/CYRACOM ID#

Recibi una copia traducida de este documento. Patient Initials \_\_\_\_\_

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