UVA Health

1500000

PLACE LABEL HERE.

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

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

# AUTHORIZATION FOR ACCESS BY HOSPITAL EDUCATION

(Patient's full name) _____ Birth date (Mo/Day/Yr.) _____

(Street address) _____ Phone (Home or Cell) _____

(City, state, zip code) _____ Phone (Work) _____

I _____ _____ give permission for the Hospital Education Program (HEP) to access my child's medical record. By giving this authorization, I understand the HEP may exchange information with my child's local school or community agency. 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 affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations.

**Signature of Parent or Legal Representative of Patient** _____ **Date** _____

**Printed Name of Parent or Legal Representative of Patient** _____