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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 RELEASE OF MEDICAL INFORMATION

(Patient's full name or Legal Guardian)

Birth date (Mo/Day/Yr)

(Street address)

Phone (Home or Cell)

(City, state, zip code)

Phone (Work)

I understand there is a fee of \$.50 per page for pages 1-50, \$.25 per page for pages 51+, \$1.00 per page for microfiche, plus actual postage if mailed. Fees are waived when copies are requested by other health care provider's agencies/facilities for continuing care. All other requestors are charged as state and federal laws allow. Photo ID is required.

I _____, hereby authorize **University of Virginia Health System**, to release:
(patient, legal guardian)

COPIES OF MEDICAL RECORDS:

- PERTINENT ELEMENTS ONLY (MOST RECENT DISCHARGE SUMMARY, HISTORY & PHYSICAL, AND OPERATIVE RECORD) (NO FEE)
- OTHER ELEMENTS (FEES APPLICABLE)
 - Immunization Record
 - X-Ray and Imaging Report [date(s)] _____
 - Clinic Notes [date(s)] and Doctor's Name: _____
 - Emergency Room Record [date(s)] _____
 - Other: _____
 - Pharmacy: (For Patient Assistance Program) Allergy Inform Diagnosis Financial Insurance Medication

MEDIA TYPE:

- Portal (email address required)
- CD Paper

INFORMATION ACCESS:

- Medical Records Review by UVA Health Care Provider (Not related to case)
- Verbal Disclosure of Information

I understand that I am giving my permission to release 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:

INFORMATION RELEASE TO:

NAME (Physician, hospital, agency, etc.)

Street address

City, state, zip

- Purpose of Disclosure:**
- Personal Insurance Attorney Workers Comp
 - Requested for UVA LIP (physician, NP, PA) to review the medical record Exchange of Information verbally with non-UVA entity

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 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. I understand that the University of Virginia Health System may not condition its providing of health care on whether copies to individuals or organizations as I request.

Signature of Patient or Legal Representative of Patient

Date

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

Patient's Authorized Representative

Date