Medical Records Release Authorization

Patient: _____ DOB: _____ Phone: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

PLEASE **RELEASE** INFORMATION **TO:**

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

_____
*E-Mail

_____*By initialing this box, I acknowledge that my personal health information will not be protected if WHSC sends my personal information by email. I understand WHSC's email is not HIPAA compliant. WHSC will not be held responsible should my requested documents become compromised.

I authorize the following information to be diclosed (Please indicate all that apply)

☐ ___Complete Record ☐ ___Ultrasound/Sonogram Results ___STD Testing

☐ ___Labs Results ☐ ___Progress Notes ___ Other_____

REASON for disclosure of health information: (Please indicate all that apply)

☐ ___Following Previous WHSC Provider ☐ ___Personal Use ☐ ___Dissatisfied

☐ ___Moving ☐ ___Insurance ☐ ___Job/School

___Transferring to a new physician ___Legal/Attorney ___Other_____

☐ ___Want to deliver at Mary Washington ☐ ___Continuing Care

Please initial each item below to indicate your understanding.

____I acknowledge that VA law allows for reasonable copy fees: $10.00 Administration fee, $0.50 per page for the first 50 pages and $0.25 a page thereafter.

____I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____
PATIENT SIGNATURE (or Signature of Person Completing Form if Not Patient) DATE

Relationship to patient: __ Parent __ Legal Guardian __ Other:

_____
SIGNATURE OF WITNESS DATE

OB/GYN
WHSC
Your Journey Together