



Medical Records Release Authorization

Patient: _____ : _____ Phone: _____

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

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

Name of Provider/Clinic/Organization

Name of Provider/Clinic/Organization

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Phone Number

Fax 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 disclosed (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)

Relationship to patient: Parent Legal Guardian Other:

SIGNATURE OF WITNES