Authorization for Release of Protected Health Information

Provide the patient with a copy of the signed form

Patient Name:____

Address:____

Date of birth:____________________ SSN:______________________ Phone Number: __________________________

Date of Request:________________________

I would like the following access, use, or disclosure:

Copy of my records sent to me:

Please allow seven to ten business days to process. A fee will apply.

____Please check here if you prefer to pick your records up. Otherwise, they will be mailed to the address above.

Copy of my records sent to another doctor or entity:

Please allow seven to ten business days to process.

I request and authorize Virginia Women's Center to release health care information of the patient named above to:

Name: ____

(Name of individual or entity to receive the information)

Address: ____

City, State: ______________________________ Zip code: ____________________

Office Telephone #: ______________________ Office Fax #: ______________________

Opportunity to inspect my records:

The department manager will contact you to schedule a convenient date and time to inspect your records.

Other, Please describe:____

I am requesting the following records:

Entire Chart

Obstetric and/or Gynecological Records: All Records:_____ or Specific Date(s):_____________________________

Mammography films: All Records:_____ or Specific Date(s):_____________________________

Urology Records: All Records:_____ or Specific Date(s):_____________________________

Other: ____

This protected health information is being used or disclosed for the following purposes:

At the request of the individual   Consultation/Second Opinion   Moving

Changing Physicians   Insurance   School

Other – please describe____

I understand that this authorization will be valid for 6 months.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to:

Virginia Women's Center
Attn: Centralized Medical Records
5875 Bremo Road, Suite 400
Richmond, VA 23226

Fax # 804-282-2601
Phone # 804-288-4084

I understand that once this information is released by Virginia Women's Center, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

I understand that Virginia Women's Center will not condition my treatment on whether I provide authorization for the requested use or disclosure unless the treatment requested is for the sole purpose of providing specific information to the party named above. (This includes but is not limited to Employee Physicals and treatment for Workers Compensation)

If applicable, signing this authorization may result in permission for my physician to receive direct or indirect payment to the Virginia Women's Center from a third party based on the use or disclosure of my medical information.

____ ______________________________

Signature of Patient / Personal Representative Date

____

Printed Name of Patient / Personal Representative

____

Description of Personal Representative's Authority

OFFICE USE ONLY:

☐ OB ☐ GYN

Date received: ____________ Date processed: ____________ Fee Paid (if applicable):_______

Processed by: ____________ Manager Review: ____________ PHI Logged: _______