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:_____ Email address: _____

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

☐ Copy of my records sent to me:

If your email address is on file with us, your records will be sent to you via secure message within three business days. This is a no charge option. You can update your email address anytime via the My Profile section of our secure patient portal.

If you do not have an email address on file with us or you prefer not to receive your records via secure message, select from the options below. Please allow 7 to 10 business days for processing. A fee will apply

____I prefer to pick my records up.

____I prefer my records be mailed to the address listed above. *

☐ Copy of my records sent via fax to another doctor or entity. A fee will apply.

Please allow 7 to 10 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 #: _____

☐ Other, please describe: *_____

I am requesting the following records:

☐ Clinical History. The clinical history package contains the most commonly requested information for transferred records: Lab Results, Vital Signs, Past Medical Hx., Surgical Hx., Mammogram results, Current Medication List, Allergies and Adverse Reactions, Current Problem List, Immunization Record.

I acknowledge, and hereby consent to such, that the released information may contain sensitive information, such as: alcohol, drug abuse, psychiatric, genetic information, HIV testing, HIV results or AIDS information._____ *(Please Initial)*

☐ Mammography: ☐ Images ☐ Reports All records:_____ or specific date(s):_____

☐ Psychological records: All records:_____ or specific date(s):_____

☐ Urology records: All records:_____ or specific date(s):_____

☐ Other: _____

* Sharecare HDS has been contracted to provide this service and will invoice you directly. Pre-payment is required prior to release of records. To contact Sharecare please call 877.270.4365.

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
7130 Glen Forest Drive, Suite 101
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