VIRGINIA HOSPITAL CENTER

PHYSICIAN GROUP

VHC PHYSICIAN GROUP AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name | Date of Birth

Street Address | Home Phone #

City, State, Zip | Work Phone #

I hereby authorize and request _____ (Physician Name) to provide access to and photocopy of my medical records to _____ (Practice Name) for the purposes of Continued Medical Care. Unless specified otherwise below, this request applies to my complete medical record as currently held by: _____ at _____

Phone: _____; Fax: _____

Covering records for the period from: _____ (Date (approximate)) to _____ (Date (approximate))

Items to be excluded from this request: _____

Indicate the address and/or fax number of where records should be mailed or faxed:

IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2)

I hereby consent to the release of any and all records for the treatment of alcohol or drug use.

I hereby authorize that records release should also include treatment or evaluation for psychiatric and/or HIV/AIDS conditions.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to VHC Physician Group _____(Practice Name). I understand that 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition this authorization will expire in 1 yr from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need notsign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that there may be a charge for searching, handling, maintaining reviewing, and preparing copies in accordance with 8.01-413 of the Code of Virginia.

Signature of Patient | Printed Name | Date

Signature of Legal Representative | Printed Name | Date