PO Box 1000, Fishersville, VA 22939
540.932.4000 or 540.332.4000

REQUEST AND AUTHORIZATION TO COPY/RELEASE HEALTH INFORMATION

Please fill out *all* sections or the form may be returned to you.

Date of Request:

Section I: PATIENT INFORMATION

Patient Name: (last, first, middle initial)			Birth date:
Address:			
City:	State:	Zip:	Phone Number:

Section II: INFORMATION REQUESTED

I authorize Augusta Health to disclose/release the following information during the term of this Authorization: *Check all that apply*

☐ Cardiac Cath report	☐ Oncology report
☐ EKG/EEG	☐ Pathology report
☐ ER records	☐ Progress Notes
☐ Hospitalization (H&P, Consult, Test Results, Op Note, Disch Summary)	☐ Radiology (x-ray) film
	☐ Radiology (x-ray) report
☐ Lab report(s)	☐ Therapy Notes (specify: PT, Speech, OT, _____
☐ Records related to: _____ (e.g. car accident, appendectomy, etc.)	☐ Other reports:_____

For the following dates of treatment: (for example: specific date 1/29/09; range of dates Jul-Oct 2010; all dates of service

Section III: RECIPIENT AND PURPOSE:

If this information is not being delivered to me, then deliver my health information to: (for example: insurance company, attorney, school, etc.)

Name of Person:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip:	

The purpose of this disclosure:

☐ For continuing medical care ☐ For legal purposes
☐ For personal use ☐ For Social Security/Disability
☐ Other (specify): _____

Section IV: SPECIFIC CONSENT

By checking any of the boxes below, I am specifically authorizing Augusta Health to disclose the category of confidential information indicated next to the box, if applicable to this authorization. **I understand that Augusta Health needs my specific consent to disclose related information.**

☐ Information about the diagnosis or treatment of mental health
☐ Psychotherapy Notes (which are not part of the official medical record)
☐ Information about HIV/AIDS test results, infection status, or treatment
☐ Information about the diagnosis or treatment of drug or alcohol abuse

Section V: EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (check one preference)

☐ From the date of this Authorization until the following date: _____.
☐ Until the purpose is fulfilled
☐ Until the following event occurs: _____.
☐ Other: _____.

If no termination date/event is filled in, then this Authorization will expire 1 year after the date signed below.

- If I have questions about disclosure of my health information, I can contact the Health Information Management Department @ 932.4652 or 332.4652.
- I understand that I may change my mind and revoke this Authorization in writing at any time by notifying Health Information Management. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Augusta Health has already taken action where it relied on my permission. *Send revocations to: Health Information Management, 78 Medical Center Drive, Fishersville, VA 22939, Attn: HIM Director.*
- I understand that I have the right to inspect or copy any information disclosed under this authorization.
- I understand that once my health information is disclosed to the recipient, Augusta Health cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.
- I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected unless (a) the only purpose of the treatment is to create health information for the disclosure listed above, or (b) if my treatment is related to my participation in a research study.

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient and sign this document. This verifies that I authorize the release of the protected health information under the terms stated above.

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased
Proof of designation must be on file or sent with this request.

_____ _____
Signature of Patient or Personal Representative* **Date**

_____ _____
Name of Personal Representative* (if applicable) **Relationship to Patient**

***The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.**

Proof of designation verified by: _____
Photo ID Verified by: _____

Note: *There will be a charge for personal copies of your records. Healthport has been contracted to provide this service and will invoice you directly.*

Medical Information Released by Healthport

Entire _____ DS _____ EKG _____ H&P _____ Immunizations _____ Lab _____
Op _____ Path _____ Rad _____ Other _____ _____ _____ _____

ROI Specialist: _____ Date: _____

Orig 1/03 Rev 4/03, 6/04, 2/08, 3/08, 5/08, 12/08, 11/09, 5/10, 1/11, 6/11, 7/12