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

Please specify the Protected Health Information to be released by first marking the following:
Are you requesting psychotherapy notes? ☐ Yes, then you may only request psychotherapy notes on this authorization. You must submit a separate authorization for other items. ☐ No, then you may check as many items below as you need. *Check all that apply*

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

For the following dates of treatment: (for example: specific date 1/29/09; range of dates Jul-Oct 2010; ED visit in May, etc.)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing results or AIDS information. _____ (initial)

The **purpose** of this disclosure is for ☐ Continuing medical care, ☐ Changing PCP/Family Physician, ☐ Personal use, ☐ Insurance processing, ☐ Legal, ☐ Other (specify) _____.

Section III: RECIPIENT INFORMATION

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 to Receive Information:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip:	

Section V: EFFECTIVE DATE OF AUTHORIZATION

This authorization will be in effect for one (1) year from the date signed, unless a shorter period is indicated below:

Date or event on which this authorization will expire: _____

I understand that:

- If I have questions about disclosure of my health information, I can contact the Health Information Management Department @ 932.4640 or 332.4640.
- 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 have the right to inspect or copy any information disclosed under this authorization.
- 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.
- 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. **Proof of designation must be on file or sent with this request.** ☐ Minor ☐ Incompetent ☐ Deceased

_____ _____

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. Ciox Health has been contracted to provide this service and will invoice you directly.

Medical Information Released by Ciox Health

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

ROI Specialist: _____ Date: _____