



Radiology Department  
 PO Box 1000, Fishersville, VA 22939  
 540.932.4400 or 540.332.4400

**REQUEST AND AUTHORIZATION TO COPY/RELEASE HEALTH INFORMATION**  
 Please fill out *all* sections or the form may be returned to you.

<b>Section I: PATIENT INFORMATION</b>			<b>Date of Request:</b>	
Patient Name: (last, first, middle initial)			Birth date:	
Address:			AH MR#:	
City:	State:	Zip:	Phone Number:	

**Section II: RADIOLOGY INFORMATION REQUESTED**

I authorize the below facility to disclose/release the following Radiology images and reports during the term of this Authorization:

Facility Name:	
Facility Address:	
Facility Phone:	Facility Fax:

*Check all that apply*

<input type="checkbox"/> CT <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> GU (Genito-urinary) <input type="checkbox"/> Ultrasound <input type="checkbox"/> Records related to: _____ (e.g. car accident, appendectomy, etc.)	<input type="checkbox"/> MRI <input type="checkbox"/> Bone <input type="checkbox"/> Neuro <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Mammography <input type="checkbox"/> Other reports: _____
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<b>For the following dates of treatment:</b> (for example: specific date 1/29/13; range of dates Jan-June 2013; all dates of service)
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**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 Organization: <b>Augusta Health Radiology Department</b>	
Street Address: <b>P.O. Box 1000</b>	
City, State, Zip: <b>Fishersville, Virginia 22939</b>	
Phone Number: <b>540-332-4483</b>	Fax: <b>540-332-4300</b>
<b>The purpose of this disclosure:</b>	
<input type="checkbox"/> For continuing medical care <input type="checkbox"/> For personal use <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> For legal purposes <input type="checkbox"/> For Social Security/Disability

**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.**

<input type="checkbox"/> Information about the diagnosis or treatment of mental health <input type="checkbox"/> Psychotherapy Notes (which are not part of the official medical record) <input type="checkbox"/> Information about HIV/AIDS test results, infection status, or treatment <input type="checkbox"/> Information about the diagnosis or treatment of drug or alcohol abuse
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**Section V: EFFECTIVE DATE OF AUTHORIZATION**

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

<input type="checkbox"/> From the date of this Authorization until the following date: _____. <input type="checkbox"/> Until the purpose is fulfilled <input type="checkbox"/> Until the following event occurs: _____. <input type="checkbox"/> Other: _____
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**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.**