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

Augusta Health
Radiology File Room
78 Medical Center Dr.
Fishersville, VA 22939
Tel# 540-332-4400 Opt #2
Fax# 540-332-4300

☐Patient Here

☐Minor Patient

Section I: PATIENT INFORMATION

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

Section II: RECIPIENT AND PURPOSE:

☐ Information is to be delivered to me, the patient. (If this box checked, skip to **Purpose of Disclosure**)

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

Name of Facility / Organization:	
Street Address:	
City, State, Zip:	
Phone Number:	Fax:

The Purpose of this Disclosure:

☐ For continuing medical care ☐ For legal purposes

☐ For personal use ☐ For Social Security/Disability

☐ Other (specify): _____

Information to be copied/released:

Exam Name	Date of Exam	Exam Name	Date of Exam

Please check ( ) appropriate box:

☐ CD Pick up - Name of person / office picking up CD:_____Date of Pick-up _____

☐ CD to be mailed **(See Box "II" for additional info needed)**

☐ CD to be sent via Fed-Ex, UPS, Cert. Mail, (Etc.) ID Tracking # _____

☐ Send via Courier - Office / Physician name: _____

☐ Electronic transmission to Patient / Physician - Email: _____

Section III: 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: _____

- If I have questions about disclosure of my health information, I can contact the Health Information Management Department @ 540.332.4640.
- 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 therecipient will not redisclose the health information to a third party or as required by law. The third party may not berequired 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 andsign 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** ☐**Other** **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 caresurrogate, or other person.**

For Radiology Use Only:

Filled out by:_____ Packaged by:_____ Distributed by: _____