AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

Please specify the Protected Health Information to be released by checking all that apply below:

☐ Hospitalization (H&P, Consult, Test Results, Op Note, Discharge Summary) ☐ Progress Notes ☐ History & Physical ☐ Cardiac Cath Report ☐ Emergency Room Records ☐ Lab Report(s) ☐ Records related to:_____ (e.g., car accident, appendectomy, etc.)	☐ Oncology Report(s) ☐ Pathology Report(s) ☐ Radiology (x-ray) film(s) ☐ Radiology (x-ray) report(s) ☐ Surgery Report(s) ☐ Therapy Notes (specify PT, Speech, OT: _____) ☐ EKG/EEG ☐ Other records:_____
For the following dates of treatment: (e.g., specific date 10/10/2023; range of dates Jan. to Nov. 2023, ED visit in May, etc.)	

If I have been diagnosed or treated for any of the following, I understand that I must give my specific consent by checking the applicable box below before a Healthcare provider can send them to this requester.

A. I (☐ **DO** ☐ **DO NOT** ☐ **N/A**) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.
B. I (☐ **DO** ☐ **DO NOT** ☐ **N/A**) authorize disclosure of information which refers to treatment or diagnosis of mental health.
C. I (☐ **DO** ☐ **DO NOT** ☐ **N/A**) authorize disclosure of information which refers to HIV test results, infection status, or treatment.

Reason records are needed (check all that apply):

☐ Continuing medical care ☐ Social security/disability ☐ Legal
☐ Personal use ☐ Other (specify):_____

If this information is not being delivered to me, then deliver my health information to:

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

EFFECTIVE DATE OF AUTHORIZATION

This authorization will be in effect for one (1) year from the date of signature, 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 Health Information Management Department at (540) 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 acted where it relied on my permission. Send revocation to: Health Information Management, 78 Medical Center Drive, Fishersville, VA 22939
- Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned with my signing this Authorization.
- The information used or disclosed as part of this Authorization may be subject to re-disclosure again by the recipient and may no longer be protected by applicable privacy law.

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 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 Legal Representative* **Date**

_____ _____

Name of Legal Representative* (if applicable) **Relationship to Patient**

***The Legal 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: Augusta Health has partnered with HealthMark Group to ensure the accurate and timely completion of medical records requests. HealthMark Group fulfills all patient requests for personal digital copies at no charge to the patient. By default, your record will be sent to you via email. In the event you require a paper copy to be delivered, you will be asked to pay any associated shipping fees. If you have any questions, contact HealthMark at 800-659-4035 or by email at augustahealth@healthmark-group.com