_____ (Print Patient's Full Name) _____ Birth Date (Mo/Day/Yr) _____ Medical Record Number	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION**

_____ _____
(Street Address) Home Telephone Number

_____ _____
(City, State, Zip Code) Work/Cell Phone Number

INFORMATION TO BE RELEASED:

Inpatient Date: _____
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ History & Physical
- ☐ Progress Notes

☐ Other Data _____
Specify Data Type & Date of Visit/Testing

☐ Emergency Department Date: _____

☐ Clinic Visit Date: _____

☐ Physician's Office Date: _____

☐ Pathology Report ☐ Radiology Report ☐ Laboratory Report
☐ EKG/EEG/CARDIAC CATH Report

☐ **SEND RECORDS ELECTRONICALLY TO THIS EMAIL ADDRESS:** _____
(*This option applies **only** to requests for inpatient records*)

☐ **RECORDS ARE TO BE MAILED TO:**

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

RECORDS MAY BE FAXED FOR CONTINUITY OF CARE ONLY: Fax #: _____

As the person signing this authorization, I understand that I am giving my permission to the VCU Health System for disclosure of confidential health care records to include, if applicable, PSYCHIATRIC, DRUG/ALCOHOL, HIV, the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses, testing/treatment, and/or other information contained in the medical record, unless indicated otherwise in the following "Special Instructions".

Special Instructions: _____

Purpose of Disclosure:

☐ Physician ☐ Insurance ☐ Legal ☐ Worker's Compensation ☐ Disability Determination
☐ Personal ☐ Other (Please specify): _____

NOTE: There will be a charge for copies of records for personal, legal or insurance purposes. HealthPort has been contracted to provide this service and will invoice you directly. HealthPort cannot provide copies of actual radiologic images, x-ray films, ultrasounds, or pathology slides; requests for copies of those items must be directed to the department/clinic where they were obtained or prepared.

I also understand that I have the right to revoke this authorization, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. ***This authorization will expire 12 months from the date of signature.*** *A copy of this revocation shall be filed in my original records; also a copy of the authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this authorization pertains are not authorized to redisclose them to anyone else without my separate written authorization, unless such a recipient is a provider who makes a disclosure permitted by law. However, this potential exists. I understand that the medical provider to whom this is furnished may not condition my treatment on whether or not I sign the authorization.*

_____ _____ _____
Signature of Individual or Guardian or Personal Representative of Patient's Estate *Relationship to Patient* *Date*

_____ _____
Witness *Date*

When records are requested from another facility for continuity of care, the patient's authorization is NOT required. This form may be used to obtain or request information from another facility whether it is signed by the patient or not.

RETURN SIGNED RELEASE TO:
HealthPort, P.O. Box 980679, 403 North 13th Street
Richmond, VA 23298
Phone: 804-828-4379, Fax: 804-828-5344