Name MRN (Patient identification)	**VCU Health System** **MCV Hospitals and Physicians** **Richmond, Virginia 23298** AUTHORIZATION TO OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION

Health care provider, hospital or agency information is to be obtained from:

Name: ______________________________

Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Patient for whom information is to be obtained:

Patient name: ______________________________

Date of birth: ______________ M.R. No.: ______________

Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Home phone: ______________ Work phone: ______________

Treatment area: *(Circle area)* Inpatient: ______________ Emergency Dept: ______________
Date(s) Date(s)

Clinic: ______________ Physician's office: ______________
Date(s) Date(s)

Other: ______________ Date(s): ______________

Information or records to be disclosed (medical records, X-ray films, pathology, slides, etc.):

____

I understand that I am giving my permission to ______________________________ ***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: ______________________________

____

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. 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 whom disclosure was made shall be included with my original records. The person who receives the records to which this authorization pertains may not re-disclose them to anyone else without my separate written authorization, unless such a recipient is a provider who makes a disclosure permitted by law.

______________________________ ______________________________

Signature of patient or guardian/next of kin
(In case of minor or deceased patient)

Date
(This authorization will expire six months from above date.)

______________________________ ______________________________

Witness

Date

RETURN to department/clinic name: ______________________________

Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Phone: ______________ Fax: ______________

Name MRN (Patient identification)	**VCU Health System** **MCV Hospitals and Physicians** **Richmond, Virginia 23298** AUTHORIZATION TO OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION

Patient name: ______________________________

Date of birth: ______________ M.R. No.: ______________

Address: ______________________________

City: ______________ State: ______ ZIP: ______

Home phone: ______________ Work phone: ______________

Treatment area: *(Circle area)* Inpatient: ______________ Emergency Dept: ______________
Date(s) Date(s)

Clinic: ______________ Physician's office: ______________
Date(s) Date(s)

Other: ______________ Date(s): ______________

Information or records to be disclosed (medical records, X-ray films, pathology, slides, etc.):

____

Person or agency to whom disclosure is to be made:

Name: ______________________________

Address: ______________________________

City: ______________ State: ______ ZIP: ______

As the person signing this authorization, I understand that I am giving my permission to the MCV Hospitals and Physicians 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: ______________________________

____

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. 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 whom disclosure was made shall be included with my original records. The person who receives the records to which authorization pertains may not re-disclose them to anyone else without my separate written authorization, unless such a recipient is a provider who makes a disclosure permitted by law.

I also understand that there may be a $10 retrieval/copy fee. One to 10 pages are included in the retrieval fee. An additional fee of 50 cents per page, up to 50 pages, and 25 cents per page thereafter will be payable prior to processing the request. Unless arrangements are made for pickup of the requested documents, all copies will be forwarded to the address above via the U.S. Postal Service.

______________________________ ______________________________
Signature of patient or guardian/next of kin Date
(In case of minor or deceased patient) (This authorization will expire six months from above date.)

______________________________ ______________________________
Witness Date

RELEASED from department/clinic name: ______________________________

Address: ______________________________

City: ______________ State: ______ ZIP: ______

Phone: ______________ Fax: ______________