University of Virginia Health System
Patient Financial Services Department
P O Box 800750
Charlottesville, Virginia 22908 • Telephone: (434)982-4330

005AUTH

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION

DO NOT RELEASE INFORMATION IF THIS AUTHORIZATION IS NOT COMPLETELY FILLED OUT – ALL BLANKS MUST BE COMPLETED

Patient Name _____ MRN (For UVA use only) _____

Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ S S # _____

Home Telephone Number _____ Work Telephone Number _____

1. **I authorize the use or disclosure of the above named individual's health information as described below:**
2. **The following individual or organization is authorized to disclose my medical information:**

   Name UVA Health System Patient Financial Services

   Address P.O. Box 800750 Charlottesville, VA 22908
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ Information sheet relative to Payscale and Responsibility Code data.

   ☐ Documentation Requirements checklist for financial assistance verification.

   ☐ Itemized bills for dates of service _____ through _____.

   ☐ Other (Must be specific) _____
4. I understand that I am giving my permission to release copies of information that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions: _____
5. **This information may be disclosed to the following individual or organization:**

   Name _____

   Address _____

   For the purpose of _____

   (If the patient or representative is requesting this release of information, s/he may fill in this blank with "at the request of the individual")
6. I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to Patient Financial Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in six (6) months from the date signed, unless an expiration date, event or condition is specified as follows: _____
7. I understand that the information disclosed to the above individual or organization may be redisclosed and not be protected by the federal Privacy Rule. If I have questions about disclosure of my health information, I may contact the Customer Service Office of Patient Financial Services.
8. I understand that the UVA Health System cannot condition its providing of health care on whether or not I sign this authorization, unless I am requesting care specifically for it to be disclosed under this authorization (for example, a physical for school enrollment).
9. In the event UVA Health System provides copies to individuals or organizations as I request, I understand there is a fee of $.50 per page. Fees are waived when copies are sent to other health care providers/agencies/facilities. All other requestors are charged as state and federal laws allow.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Describe Authority to Act on Patient's Behalf