Health Information Management Department
1701 North George Mason Drive
Arlington, VA 22205
Phone: 703-558-6116 FAX: 703-558-6979

Medical Record Number _____
Date/Time Doctor's Appointment _____
Doctor's Phone/Fax Number _____

(1) _____ (2) _____
Patient's Name at Time of Treatment **Date of Birth**

(3) _____ (4) _____
Street Address **Home Phone Number**

_____ _____
City **State** **Zip Code** **Work / Cell Phone**

(5) The undersigned hereby authorizes and requests Virginia Hospital Center to provide access to my medical record for the purpose of:
☐ **Continued Medical Care** ☐ **Personal** ☐ **Legal** ☐ **Other:** _____
Provide records by means of: ☐ **Mail** ☐ **Pick-Up** ☐ **Fax* - Records will only be faxed for immediate direct patient care to physician offices, hospitals, or other treatment facilities. (Patient is in office/facility receiving treatment) Items listed in # 9 and #10 will not be faxed.** ****Charges may apply for record copies****

(6) _____
Identity of Person or Organization to send your records to. Fill in completely even if records are returning to you.

_____
Street Address **City** **State** **Zip Code**

The foregoing is subject to such limitations as indicated below:

(7) Covering records for the period from: **(Date)**_____ to **(Date)**_____. Date range is acceptable.

(8) Confined to the following specified information: Please check what information is needed.

☐ Discharge Summary Reports
☐ Emergency Room Record
☐ Progress Notes
☐ History and Physical Report
☐ Outpatient/Clinic Record
☐ Operative Reports and Pathology Reports
☐ Lab Report
☐ Physician's Orders
☐ Consultations
☐ X-ray, MRI, Ultrasound, and/or CT scan Reports
☐ EKG Findings
☐ Abstract (all dictated reports/ Labs/Rad/EKG)
☐ Other: _____

*****Fee for copies are $.50/page up to 50 pages + $.25/page starting with 51st page.***
*****Nursing notes available upon request with fees applied~***
VHC has contracted with HEALTHPORT Copy Service, (GA), to process release of record copies and billing for copies of medical records. HEALTHPORT questions? Please call 1-800-464-0035.

(9) IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2)
I hereby consent to the release of any and all records for the treatment of alcohol or drug use.

(10) I hereby authorize Virginia Hospital Center to release to the above named source the following information for the period(s) identified above: All medical records or other information regarding my treatment, including treatment or evaluation for psychiatric and/or HIV/AIDS conditions.

(11) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition this authorization will expire 1 year from the date signed.

(12) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director/Privacy Officer at 703-558-6972. Virginia Hospital Center is not responsible for any re-disclosure of the information provided.

(13) I understand that there may be a charge for searching, handling, maintaining, reviewing, and preparing copies in accordance with 8.01-413 of the Code of Virginia.

(14) _____ (15) _____ / _____
Date **Signature of Patient** **Printed Name of Patient**

(16) _____ / _____
Signature of Legal Representative **Printed Legal Representative**

RI001

VIRGINIA HOSPITAL CENTER

Authorization for Release of Medical Record Information

121917-8400-061613

Patient Label

Virginia Hospital Center's
INSTRUCTIONS FOR COMPLETING
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

To insure the timely processing of your request, please fill out entire form, lines 1-16. VHC will not be able to process your request without it.

Items 1-4: Name should be the name of the patient at the time of treatment.

Item 5: Please check one box for the "Purpose" of the request.
Please check one box for the "Means" of the request.

If means of delivery is "Fax", **Virginia Hospital Center only faxes directly to medical facilities/offices** and only if records would not reach facility/office by mail in time for any appointment indicated at the top of the authorization. Please provide both the fax number and phone number of the medical facility/office at top of page. You will then need to complete Item 6 with the doctor's name and address.

***PLEASE NOTE: If means of delivery is "Pick Up", you will receive a phone call when record copies are ready. You will then have 5 business days to pick up record copies. After the 5th business day, record copies are destroyed. A bill will be automatically generated whether or not record copies are picked up. If you fail to pick up record copies after the first request, any additional requests will incur additional charges.**

Item 6: ***DO NOT FILL IN WITH "SELF" OR "SEE ABOVE". MUST FILL IN COMPLETELY.** This information MUST be provided. Write the name and full address of person you want to receive the copies, even if they are being sent to yourself.

PLEASE NOTE: Person identified in this line will be billed.

Item 7: You need to indicate specific dates OR a range of dates covering the dates of the visit. If it was a one-day visit, repeat the same date after date "to" as you indicated after date "from".

Item 8: HIPAA guidelines limit Virginia Hospital Center to release "minimum necessary" to medical facilities. Our policy is to limit faxes to 10 pages, including Discharge Summary, History and Physical, Labs, Radiology ("Xray…"), EKG's and Operative Reports/Pathology. If the visit was ER only, the Emergency Room Record will be sent in full, unless only specific parts are indicated on your request. The physician may make a direct or subsequent request for other reports needed for continuing care. **Again, we only fax records to physicians and other hospitals.**

You as the patient, may request a copy of your records for your own personal use
You must complete an Authorization for Release of Medical Record Information form**.**
Please note that there is a copy fee for a copy of your record. The fee is as follows:
$. 50 per page up to 50 pages, $ .25 per page 51+ pages, $1.00 per page for copies made from microfiche, and postage. Our processing time is 15 days.

Items 9-13 The space on Item 11 may be left blank if you agree to an expiration timeframe of 1 year. If you wish the timeframe to be shorter, you may indicate a specific date or timeframe.

Items 14-16 Please enter the date that you are signing and your signature. **If you have POA or you are the administrator for a deceased patient, we will need additional documentation. Please call us for details.**

If you have any questions, please call the Health Information Management department at (703) 558-2403.