

AUTHORIZATION FOR RELEASE OR OBTAIN OF MEDICAL INFORMATION

 (Print patients full name)

 (Birth date (Mo/Day/Yr))

 (Street address)

 (Last 4 digits SSN)

 (City, state, zip code)

 Phone (Primary)

 (Parent/Guardian if Patient<18 yrs)

 Chart #

 Information to Be Released to:

 Obtained From:

 Street Address

 City, State, Zip Code

 Fax

At the request of the individual, I _____, do hereby authorize Virginia Urology to release ____ or obtain ____ the health
 (Patients Name)

information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include physical and mental illness, alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnosis.

_____ **I would like to obtain my records through the secure web portal**

_____ Please release the following at no charge, last 2 office notes, last lab, last CT/KUB/procedure for continuing care

_____ Please release the following at my expense according to Virginia State Rates.

If requesting leave – Start Date - _____

SPECIFIC DATES: FROM _____ TO _____

If requesting Intermittent leave:

Reason _____ Frequency _____ times per _____ week _____ month.

Information to be released <input type="checkbox"/> or Obtained <input type="checkbox"/>		Purpose of Release	
<input type="checkbox"/> Discharged Summaries <input type="checkbox"/> History & Physical <input type="checkbox"/> Hospital Notes <input type="checkbox"/> Immunization Records Clinic Notes	<input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Image <input type="checkbox"/> Operative Reports <input type="checkbox"/> EKG's <input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other	<input type="checkbox"/> Personal <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Payment of Insurance Claim <input type="checkbox"/> Disability Determination <input type="checkbox"/> Treatment/Continued Care <input type="checkbox"/> Other _____

_____ I would like to communicate with Virginia Urology using e-mail. I understand that the email may contain my protected health information, and that Virginia Urology will apply reasonable safeguards, using encryption, when communicating with me by email.

_____ If my operating system does not support the encryption used by Virginia Urology, and I cannot view the emails, then I request to receive unencrypted emails understanding the risk of disclosure.

EMAIL ADDRESS – Please print legibly - _____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is **valid for 12 months** from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: Virginia Law permits a charge for personal copy / transfer of your records. SHARECARE has been contracted to provide this service and will invoice you directly. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

 Signature of individual or guardian or
 Personal Representative of patient's estate

 Date

Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY SHARECARE

 Rep

 Date