Phone: (804) 272-1438 ♦ Fax: (804) 521-1061

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 ❑ or Obtained ❑			Purpose of Release
__ Discharged Summaries __ History & Physical __ Hospital Notes __ Immunization Records Clinic Notes	__ Laboratory Reports __ Radiology Reports __ Radiology Image __ Operative Reports __ EKG's __ Pathology Reports	__ Other	__ Personal __ Worker's Compensation __ Legal Purposes __ Payment of Insurance Claim __ Disability Determination __ Treatment/Continued Care __ 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 **Date**
Personal Representative of patient's estate
Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY SHARECARE

Rep _____ ***Date*** _____