Patient's Name: _____ History #: _____

Patient's Date of Birth: _____ Date(s) of Service: _____

Patient's phone number: (_____) _____ (_____) _____
DAYTIME EVENING

I authorize: _____

to release or disclose the following information to:

_____ _____
NAME OF PERSON, PHYSICIAN OR AGENCY TO RECEIVE INFORMATION (FAX NUMBER FOR PHYSICIAN OFFICE ONLY)

_____
STREET ADDRESS CITY STATE ZIP CODE

Information to be Released / Disclosed:

❑ Emergency Record	❑ X-ray Report	❑ Billing Information
❑ Face Sheet	❑ Progress Notes	❑ Substance Abuse Records
❑ Discharge Summary	❑ Lab / EKG	❑ Plan of Care (HH)
❑ Psychiatric Admit Note	❑ Operative Report	❑ Complete Health Record
❑ Psychiatric Evaluation	❑ Physicians Orders	❑ Medical Abstract
❑ Consultation	❑ Other _____	❑ X-ray Films/CD

Purpose:

❑ Medical Follow-Up	❑ Individual use	❑ Insurance
❑ Attorney	❑ Disability	❑ Other _____

Patient advised of charges: ❑ Yes ❑ No ❑ N/A

❑ I prefer to pick up records ❑ I wish to review records (by appointment only)

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that I am under no obligation to sign this form. Inova Health System may, however, condition the provision of research-related treatment on my signature of this authorization for the use or disclosure of protected health information for such research, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, §164.508(b)(4). Inova Health System may also condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE (This authorization will expire 6 months after date signed)

_____ _____
NAME OF PERSONAL REPRESENTATIVE (IF APPLICABLE) RELATIONSHIP TO PATIENT

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

INOVA INITIATED AUTHORIZATION TO RELEASE / DISCLOSE PROTECTED HEALTH INFORMATION

CAT #84515 / R032403 • PKGS OF 100