

INSTRUCTIONS FOR COMPLETING

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

To insure the timely processing of your request, please read all items listed below.

- Items 1-4: Name should be the name of the patient at the time of treatment.
- Item 5: Two (2) boxes should be marked: one for “Purpose” of the request and one for the “Means” of delivery. **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 fax number and phone number here. You will then need to complete Item 6 with the doctor’s name and address.
- Item 6: 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.**
- 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 \$. 50 per page up to 50 pages and \$.25 per page 51+ pages. Older records stored on microfilm will be processed at \$1.00 per page. 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 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.

Authorization for Release of Medical Record Information

Virginia Hospital Center

Health Information Management Dept.
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) Patient's Name at Time of Treatment (2) Date of Birth

(3) Street Address (4) Home Phone Number

City State Zip Code Work 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 any duly authorized representative (name of person to send your records to)

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

(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 Nurse's Notes Lab Report Physician's Orders Operative Reports and Pathology Reports X-ray, MRI, Ultrasound, and/or CT scan Reports EKG Findings Other: Physician access to all above information via computer if available

(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 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) Date (15) Signature of Patient / Printed Name of Patient

(16) Witness (17) Signature of Legal Representative / Printed Name of Legal Representative