

PLEASE SEND TO MEDICAL RECORDS DEPARTMENT TO BE PROCESSED



SENTARA®

Sentara Potomac Hospital  
2300 Opitz Boulevard  
Woodbridge, VA 22191

### Authorization for Release of Medical Information

Medical Record Number \_\_\_\_\_ Social Security Number \_\_\_\_\_ Mail \_\_\_\_\_  
 Patient Name (at time of service) \_\_\_\_\_ Pick-up Date \_\_\_\_\_  
 Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Telephone \_\_\_\_\_  
 Work Telephone \_\_\_\_\_

The undersigned hereby authorizes and requests **Sentara Potomac Hospital** to release medical information to:  
*(full name, address, phone and fax, if known, of person to receive records)*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

All requests are billed at fifty (50) cents per page for the first fifty pages and twenty-five (25) cents per page thereafter. There is an additional \$10 fee for copies that are sent to third parties, such as insurance companies, attorneys, etc. Record requests sent to physicians or healthcare facilities for follow up care are free of charge.

Purpose of Disclosure: \_\_\_\_\_ Limits of Disclosure: \_\_\_\_\_

Date of Service From \_\_\_\_\_ To: \_\_\_\_\_  
*(date admitted) (date discharged)*

**Please check all information to be sent:**

- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ History & Physical
- \_\_\_\_\_ Laboratory & Radiology Reports
- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Operative & Pathology Reports
- \_\_\_\_\_ EKG/Catheterization Reports
- \_\_\_\_\_ Emergency Department Record
- \_\_\_\_\_ Outpatient Surgery Record
- \_\_\_\_\_ Physician's Orders
- \_\_\_\_\_ Nurse's Notes
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

By my signature below I understand that there are no limitations placed on dates, history or illness, diagnostic and therapeutic information, including treatment for HIV, alcohol and drug abuse. I also understand that this consent will automatically expire six (6) months from the date signed. Furthermore, this consent will be revoked upon completion of this request and will not serve for any future request. I understand that authorizing the disclosure of this medical 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 or copy 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 redisclosure and the information may not be protected from federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director, Health Information Management at Potomac Hospital. 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 Medical Records 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.

\_\_\_\_\_  
Date  
 \_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Patient *(If a minor, please print name)*  
 \_\_\_\_\_  
Signature of Legal Representative

Request Completed: \_\_\_\_\_  
 \_\_\_\_\_  
Date Initials