



Patient Label

Authorization to Disclose Protected Health Information



I authorize the following Sentara Hospital(s) and other Facility(s):

Physician(s) or Physician Practice(s):

Patient Information (Please Print)

Form with fields: First Name, Middle Initial, Last Name, Date of Birth, Phone, E-mail, Street Address, City, State, Zip

I authorize the following record(s) to be released:

Type of records to be released and date(s) of service (check all that apply):

- checkbox Inpatient, checkbox Emergency Department, checkbox Physician/Provider Visit Documentation, checkbox Same Day Surgery, checkbox Outpatient Testing

Time period or date of information to be released: From: (month/year) To: (month/year)

The following information will be released with your electronic visit summary:

Form with checkboxes for: Abstract, Allergies, Consultation Reports, Diagnostic Tests, Discharge Summary, Discharge Instructions, History & Physicals H&P Exam, Imaging Records, Immunization Records, Medication Lists, Nurses Notes, Operative Report, Pathology Report, Physical Therapy Records, Physician Orders, Problem List, Other, Entire Record - Dates

Delivery Methods: Choose only one option

- checkbox Paper, checkbox Mail, checkbox Pick-Up, checkbox CD, checkbox Email, checkbox MyChart, checkbox Fax (Continuity of Care Only)

Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

This information may be disclosed to and used by the following facility/person: checkbox Self, checkbox Recipient Listed Below

Form with fields: Recipient Name, Recipient Phone, Recipient Fax, Recipient Mailing Address, Recipient Email

For the Purpose of:

I understand that the medical information released may include any and all information related to treatment including information related to sexually transmitted diseases and HIV/AIDS information. It may also include information about mental health services and treatment for alcohol and drug abuse. This information will be released unless otherwise indicated: Do not release: (Initial)

I understand that I have the right to revoke this authorization at any time by submitting a written request to the facility/practice. I understand that the revocation will not apply to information that has 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.

I understand that authorizing the disclosure of my health information is voluntary. I have the right not to sign this form. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

I understand that any disclosure of information, made according to my authorization, 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 my health information, I can contact the Sentara Privacy Contact number at: 1-800-981-6667.

This authorization shall remain in effect for six months from the date of signature unless a different date is specified here (date):

- checkbox Parent or Legal Guardian, checkbox Power of Attorney, checkbox Next of Kin Deceased, checkbox Executor of Estate

Signature of Patient or Legal Representative (Please Provide Legal Documents)

Date