SENTARA®

Patient Label

Physician Practices Authorization to Disclose Protected Health Information

HIMROI

I authorize the following Facility to disclose: _____

Address: _____ Phone#: _____ Fax#: _____

To release the information from the record of:

Patient Name: _____ SSN/Medical Record Number: _____

Date of Birth: _____ Daytime Phone Number: _____

Address: _____

Documentation can be released electronically if stored in an electronic media.
Please check with your facility to determine if your health information is a candidate for electronic release.

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

☐ **Physician/provider visit documentation** (from date _____ to date _____) ☐ **Laboratory results** (from date _____ to date _____) ☐ **X-ray reports** (from date _____ to date _____)	☐ **Medication list** ☐ **Immunization record** ☐ **Billing** ☐ **Other:** _____	**For the Purpose of:** (Choose only one option below) ☐ Verbal Communication ☐ Copies of Medical Records ☐ Continuity of Care	**Delivery Methods** (Choose only one option below) ☐ Mail ☐ Pick-up ☐ Fax (Continuity of Care only) ☐ Email ☐ CD ☐ Pick-up ☐ Mail

1. I understand that the information in my health record might include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, genetic testing, and treatment f or alcohol and drug abuse. This information will be released unless otherwise indicated: **Do not release: _____ (Initial)**

2. This information may be **received** by the following facility/person(s):

Name & Address: _____

_____

Relationship: _____ **Phone #:** _____

Fax#/Email address: _____

3. I understand that I have the right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. 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. 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 in six (6) months.

4. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. 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 CFR 164.524. If Sentara requested the disclosure, please circle **will** or **will no**t in the following sentence: Sentara will/w ill not be remunerated f or this disclosure.
   _____**(Initial) Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulation.**

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 my health information, I can contact the Sentara Privacy Contact number at: **1-800-981-6667.**

☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin/Deceased ☐ Executor of Estate

_____ _____

Signature of Patient or Legal Representative Date