VCU Health System Authority

☐ VCU Health
☐ Community Memorial Hospital
☐ Tappahannock Hospital
☐ CHoR Brook Road Pavilion
(check all that apply)

Authorization to Release or Obtain Confidential Health Care Information

I, _____ hereby authorize VCU Health System to release/obtain the health information indicated below contained in my patient records to/from the recipient named below.

I understand and acknowledge that this may include information about physical and mental illness, alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnoses.

This authorization **does not include permission** to release Addiction Treatment Notes (*42 CFR Part 2*) or outpatient Psychotherapy Notes, all of which require a separate authorization. Psychotherapy Notes document private, joint, group or family counseling sessions and are separate from the rest of the medical record.

Information Requested for:

_____
Patient's Full **Name**

_____
Address

_____
City, State, Zip Code

_____
Date of Birth Phone (Home or Cell)

Information to be ☐ **Released To:** *or* ☐ **Obtained From:**

_____
Name of person, provider, institution, attorney, school, etc.

_____
Address

_____
City, State, Zip Code

_____
Phone Fax

Information to be ☐ **Released** or ☐ **Obtained**

☐ Discharge Summaries
☐ History and Physical
☐ Emergency Records
☐ Operative Reports
☐ Inpatient Notes
☐ Immunization Records
☐ Clinic Notes
☐ Therapy Notes (Speech, OT, PT)
☐ Cardiac Tests
☐ **Abstract *** (see page 2)
☐ Radiology Images
☐ Radiology Reports
☐ Laboratory Reports
☐ Pathology Reports

Other: _____

Approximate Service Dates: _____

Records to be Delivered By: (electronic delivery unless otherwise specified)

☐ Email to address:

☐ Mail on a CD (default for mailing) ☐ Mail paper copies to address above ☐ To be picked up by: _____

I understand that I have the right to revoke this authorization. My revocation will not be effective until delivered in writing to the person in possession of my records. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. A copy of my revocation shall be maintained.

Information disclosed by this authorization may be re-disclosed by the recipient and would no longer be protected by federal privacy regulations. The provider/facility will not condition treatment on whether I sign the authorization.

Each request will require a separate authorization.

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept these terms.

- **If the patient is 18 years of age or older**, the patient must sign and date this form.
- **If the patient is 18 years of age or older** and lacks the capacity to sign, a legally authorized substitute may sign and date the form. Indicate legal authority and include documentation of your relationship.
  Indicate relationship: ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Other _____
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception* exists under State or Federal law. (*see page 2 for exceptions)
  Indicate relationship: ☐ Parent ☐ Legal Guardian ☐ Other _____

Signature (required)	Printed **Name** of Person Signing	**Date Signed** (required)

This form may be used to obtain or request information from another facility for continuity of care and does not require patient authorization.

D T - M E D R E C A U T H

H-MR-0373 (rev. 06-25)
Health Information Management

Understanding Your Rights Pertaining to Your Records
(For Use and Disclosure)

Facts About Obtaining Your Medical Records

- You have the right of access to inspect and obtain a copy of your confidential health care information.
- If you would like to access your medical records online, you may go to MyChart.VCUHealth.org to sign up
- The law requires a signed authorization form which contains the criteria included on this form.
- The form must be fully completed before any medical information can be released.
- When records are requested from another facility for continuity of the care, the patient's authorization is NOT required.

* What is an ABSTRACT?

- An abstract includes information about you such as your Allergies, Procedures, Problem List, Home Meds, Immunization Record, and Social History, as well as all Doctor's Notes, Lab and Pathology results, X-ray reports, and other diagnostic test results that occurred during the visit.
- Documents NOT included in the abstract include notes by Nursing and other Allied Health providers, Medication and IV Administration Records, or Flowsheet Information such as Vital Signs, Measurements and Activities of Daily Care.

* Exceptions for patients under the age of 18

VCU Health System follows Virginia State Statute § 54.1-2969(E) with regard to a minor's access to information about care received for the conditions listed below:

- Sexually transmitted diseases
- Birth control, pregnancy or family planning
- Outpatient care for substance abuse
- Outpatient care for mental illness

Costs: VCU Health System follows Virginia State Statute § 8.01-413.

When and How Will I Get My Records?

- Your request will be completed within 10 days of receipt and will be available via a secure e-mail.
- You will be notified when your records are ready, or if the records cannot be processed within this timeframe.
- If you would like to pick up your records, or have the records mailed to the address listed on the authorization form, please indicate your choice on the form.
- Records will only be faxed for continuity of care purposes.
- Individuals picking up records must present valid government issued I.D.

How Do I Release My Medical Records?

Complete this Authorization to Release Confidential Health Care Information form in its entirety.
The form may be hand-delivered, mailed or faxed to:

VCU Health System

Release of Information/ Datavant

P. O. Box 980679 Richmond, VA 23298

Phone: 804-828-4423 FAX: 804-828-5344

Service Desk: Main Hospital Lobby, Room 1-403A