VCU Health

Community Memorial Hospital

Release of Information
1755 N. Mecklenburg Ave. /P.O. Box 90
South Hill, VA 23970
Phone: 434-_____ Fax: 434-_____

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL HEALTH INFORMATION

_____ _____
(Print Patient's Full Name) (Date of birth)

_____ _____
(Street Address) (Phone)

_____
(City, State, Zip Code)

_____
(Email Address)

Information to Be Released to □ or Obtained From □
_____ Name
_____ Street Address
_____ City, State, Zip Code
_____ Fax (Request faxed for Continuity of Care Only)

I, _____ hereby authorize VCU Health Community Memorial Hospital to release □ or obtain □ the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include physical and mental illness, alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnosis. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group or family counseling sessions that are separated from the rest of a patient's medical record.

Information to Be Released □ or Obtained □		
□ Discharge Summaries □ History and Physical □ Hospital Notes □ Immunization Records □ Clinic Notes	□ Laboratory Reports □Radiology Reports □ Radiology Images □ Operative Reports □ EKG's □ Pathology Reports	□ Other: _____ Approximate Service Dates: _____

Purpose of Release
□ Personal
□ Workers Compensation
□ Legal Purposes
□ Payment of Insurance Claim
□ Disability Determination
□ Treatment/Continued Care
□ Other: _____

I understand that I have the right to revoke this authorization, at any time except to the extent that action has been taken in reliance upon it. My revocation will not be effective until delivered in writing to the person who is in possession of my records. A copy of my revocation shall be maintained. Information disclosed pursuant to the authorization may be red-disclosed by the recipient and is no longer protected by federal privacy regulations. The provider/facility will not condition treatment on whether I sign the authorization. This authorization will expire one year from the date of the signature unless I indicate any earlier date here: _____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign this form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  □ Legal Guardian □ Healthcare Power of Attorney
- **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 the state or federal law. Please indicate your relationship:
  □ Parent □ Legal Guardian

Printed Name of Person Signing			
Signature (Required)		**Date Signed** (Required)	
Mailing Address			
City	State	Zip Code	Phone