

# AUTHORIZATION FOR RELEASE OF INFORMATION

I \_\_\_\_\_ authorize  Martha Jefferson Hospital  
(Patient Name or Legal Guardian)  Martha Jefferson Medical Enterprises (Medical practices)  
 Other: \_\_\_\_\_  
to release the information noted below to \_\_\_\_\_  
(Name of recipient(s))  
at the following address: \_\_\_\_\_

- |   |  |
|---|--|
| <b>Physician's Phone</b>  | <b>Physician's Fax</b>                                     |
| <input type="checkbox"/> Abstract (History, Discharge Summary, Operative note, Consult, Orders, Progress Notes) | <input type="checkbox"/> Medication Administration Records |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Billing & Payment History         |
| <input type="checkbox"/> Laboratory Report  | <input type="checkbox"/> History and Physical Exam         |
| <input type="checkbox"/> Pathology Report   | <input type="checkbox"/> Radiology Report                  |
| <input type="checkbox"/> Consultation Report  | <input type="checkbox"/> Emergency Department Report       |
| <input type="checkbox"/> Radiology films or images  | <input type="checkbox"/> Operative Report                  |
| <input type="checkbox"/> Mammography Films –  | <input type="checkbox"/> Other _____                       |

For Mammography Films, Please return signed authorization or films to: Martha Jefferson Outpatient Care Center; Attn: Mammography Film Library, 595 Peter Jefferson Parkway, Charlottesville, VA 22911	For all other requests, please return signed authorization to: Martha Jefferson Hospital, Health Information Management Department, 459 Locust Avenue, Charlottesville, VA 22902
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Dates of Service: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number (optional): \_\_\_\_\_  
Phone Number- Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_  
Purpose of request:  Personal use  Continuing Care  Other/state purpose \_\_\_\_\_

In the event Martha Jefferson Hospital provides copies to individuals or organizations as I request, I understand that there is a fee of \$.50 per page. Fees are waived when copies are sent to other health care providers/agencies/facilities. All other requests are charged as state and federal laws allow.

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include if applicable, **PSYCHIATRIC, SUBSTANCE ABUSE OR HIV/AIDS TESTING/TREATMENT** records and other information contained in the medical record, unless otherwise indicated under my special instructions written below. I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

Special Instructions: \_\_\_\_\_ (none if blank)

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_  
If signed by Legal representative or other than patient, indicate relationship to patient.  
 Verified signature on file  Verified Picture ID and signature Verified by employee: \_\_\_\_\_  
This Authorization is only valid for the information/purpose(s) indicated above, and **expires 180 days (6 months)** from signature date unless otherwise indicated on this authorization.



CMRSR-CS-008a