Spotsylvania Multi-Specialty
HCA Virginia Health System

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**
Provider's Name:	**Recipient's Name:**	
Provider's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event:
Date: **Event:**

Purpose of Disclosure:

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	Date of Service:	Description:	Date of Service:	Description:	Date of Service:
☐ All PHI in Medical Record		☐ Operative Information		☐ Labor/Delivery Summary	
☐ Admission Form		☐ Cath Lab		☐ OB Nursing Assess	
☐ Dictation Reports		☐ Special Test/Therapy		☐ Postpartum Flow Sheet	
☐ Physician Orders		☐ Rhythm Strips		☐ Itemized Bill:	
☐ Intake/Output		☐ Nursing Information		☐ UB-92 Claim:	
☐ Clinical Test		☐ Transfer Forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. There may be a reasonable fee to obtain a copy of the information being requested on this form.
7. I get a copy of this form after I sign it.
8. Note: There will be a charge for records in accordance with the VA code 8.01-413 $0.50 (Per page up to 50 pg) Additional $0.25 per page (from page 51 & up) + actual postage.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ or Personal Representative:	**Date Signed:**
Printed Name of Patient/Guardian/ or Personal Representative:	**Relationship of Personal Representative to Patient:**

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name _____ DOB _____ Account or Med. Rec. # _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual & Relationship to Patient**	**Comments/Instructions** *(i.e.: may pick up meds, may disclose test results, etc)*	**Patient/ Guardian Initials**

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

Leave message at home with my spouse or: NAME: _____

RELATIONSHIP: _____ DOB: _____

Leave message on cell phone. Cell phone number: _____

Leave message at work. Work phone number: _____

Leave a message on voicemail. Phone number: _____

Leave a detailed message on answering machine. Phone number: _____

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: _____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship *(if not self)*