SENTARA®

Patient Label

Authorization to Disclose Protected Health Information

HIMROI

I authorize the following Sentara Hospital(s) and other Facility(s): _____

Physician(s) or Physician Practice(s): _____

Patient Information (Please Print)

First Name:	**Middle Initial:**	**Last Name:**	
Date of Birth (MM/DD/YYYY):	**Phone:**	**E-mail (optional):**	
Street Address:	**City:**	**State:**	**Zip:**

I authorize the following record(s) to be released:

Type of records to be released **and** date(s) of service (check all that apply):

☐ Inpatient ☐ Emergency Department ☐ Physician/Provider Visit Documentation

☐ Same Day Surgery_____ ☐ Outpatient Testing

Time period or date of information to be released: From:_____(month/year) To:_____(month/year)

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

☐ ***Abstract*** *(Includes H&P, Discharge Summary, Consultations, OP Notes, Labs, X-Rays)*	☐ ***Discharge Summary***	☐ ***Physical Therapy Records***
☐ ***Allergies***	☐ ***Discharge Instructions***	☐ ***Physician Orders***
☐ ***Consultation Reports***	☐ ***History & Physicals H&P) Exam***	☐ ***Problem List***
☐ ***Diagnostic Tests*** *(lab work, radiology, Pathology, cardiology studies, EKG, ECHO, EEG, EMG, Doppler, Neuro, Pulmonary Function, Vascular, Audiology, OB/GYN, Genetic)*_____	☐ ***Imaging Records*** *(Images & Reports)*	☐ ***Other:***_____
	☐ ***Immunization Records***	
	☐ ***Medication Lists***	☐ ***Entire Record – Dates:***
	☐ ***Nurses Notes***	_____
	☐ ***Operative Report***	
	☐ ***Pathology Report***	

Delivery Methods: Choose only one option

☐ Paper ____Mail or ____Pick-Up ☐ CD___Mail or ___ Pick-Up ☐ Email ☐ MyChart ☐ Fax (Continuity of Care Only)

Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

This information may be disclosed to and used by the following facility/person: ☐ Self ☐ Recipient Listed Below

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient Email:

For the Purpose of:_____

I understand that the medical information released may include any and all information related to treatment including information related to sexually transmitted diseases and HIV/AIDS information. It may also include information about mental health services and treatment for alcohol and drug abuse. This information will be released unless otherwise indicated: Do not release:_____(Initial)

I understand that I have the right to revoke this authorization at any time by submitting a written request to the facility/practice. 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.

I understand that authorizing the disclosure of my health information is voluntary. I have the right not to sign this form. 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 45 CFR 164.524.

I understand that any disclosure of information, made according to my authorization, 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.

This authorization shall remain in effect for six months from the date of signature unless a different date is specified here (date):

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

_____ _____

Signature of Patient or Legal Representative *(Please Provide Legal Documents)* Date