VCU Health System
Virginia Commonwealth University
MCV Hospitals and Physicians
Richmond, Virginia 23298

[LABEL OR PT. NAME/MRN/DOB]

Release of Information
P.O. BOX 980679 Richmond, VA, 23298-0679
Phone: (804) 828-4423 Fax: (804) 828-5344

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTAL HEALTH CARE INFORMATION

______________________________________ (Print Patient's Full Name)
______________ (Date of Birth) M/D/Y

______________________________________ (Street Address)
______________ Phone (Home or Cell)

______________________________________ (City, State, Zip Code)
______________ Phone (Work)

______________________________________ (Email address: Records will be available via a secure web portal)

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 System 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 diagnoses. 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	☐Laboratory Reports	☐Other
☐History and Physical	☐Radiology Reports	
☐Hospital Notes	☐Radiology Images	______________________
☐Immunization Records	☐Operative Reports	
☐Clinic Notes	☐EKG's	Approximate Service Dates:
	☐Pathology Reports	______________________

Purpose of Release
☐Personal
☐Worker's 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 re-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 12 months from the date of 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 ☐Health Care 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

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

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

To Patients and Legal Designees:

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:

You have the right of access to inspect and obtain a copy of your confidential health care information. The law requires a signed authorization form which contains certain criteria included on this form. The form must be fully completed before any medical information can be released.

What is an abstract?

An abstract contains only the medical records needed by you and your providers to continue your care after discharge. The abstract usually includes, but is not limited to, Discharge Summary, History and Physical, Lab, Pathology, Operative Reports, Procedure Notes, Radiology Reports, Problem List and Medications. This is what is released unless you ask for your **legal medical record**.

What is a legal medical record?

In addition to what is in the abstract, your legal medical record has all the information needed to identify you, support your diagnosis, justify your treatment, and document your care and results.

FINANCIAL DISCLOSURE:

There will be a charge for copies of records for personal, legal or insurance purposes. Cardone Record Services has been contracted to provide this service and will invoice you directly. Cardone cannot directly provide copies of actual radiologic images, x-ray films, ultrasounds, or pathology slides; requests for copies of those items must be directed to the department/clinic where they were obtained or prepared.

COSTS:

Patients	All Other Requestors
$.50 PER PAGE UP TO PAGE 50	$10 Clerical Fee+: $.50 PER PAGE UP TO PAGE 50
$.25 PER PAGE, PAGE 51 AND UP	$.25 PER PAGE, PAGE 51 AND UP

Please note, records will be faxed at no cost directly to provider for continuity of care.

WHEN AND HOW WILL I GET MY RECORDS?:

Your request will be completed within 15 days of receipt and will be available via a secure web portal. 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 this on the authorization form. Records will be faxed only for continuity of care purposes.

HOW TO RELEASE YOUR MEDICAL RECORDS:

Complete the “Authorization to Release or Obtain Confidential Health Care Information” form in its entirety. This form can be hand-delivered, mailed or faxed to the following address:

VCU Health System
Release of Information/Cardone Record Services
P.O. BOX 980679 Richmond, VA, 23298
Phone: (804) 828-4423 Fax: (804) 828-5344
Physical Address: Clinical Support Center 3rd Floor Room 302/303B