Authorization for Release of Protected Health Information

Patient's name: _____ Birth Date: _____

Social Security Number: _____ Phone Number: _____

Date(s) of Service: _____

I authorize: _____ **Dominion Hospital** _____

to release to or receive from:

_____ _____

Name of person, physician or agency to receive information — Phone Number of receiver

_____

Street Address — City — State — Zip Code

Information to be Released/Disclosed:

- ❑ Admission History
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Consultation
- ❑ Physician Orders
- ❑ Labs/EKG's/X-rays
- ❑ Medication Records
- ❑ Nursing Assessment
- ❑ Nursing Progress Notes
- ❑ Transfer Forms
- ❑ Psychosocial Assessment
- ❑ Emergency Room Record
- ❑ Psychological Evaluation
- ❑ Psychoeducational Reports
- ❑ Physician Progress Notes
- ❑ Medical Abstract
- ❑ Itemized Bill/UB-92
- ❑ Verbal Communication
- ❑ Other _____

Purpose:

- ❑ Medical Follow-up
- ❑ Attorney
- ❑ Individual Use
- ❑ Disability
- ❑ Insurance
- ❑ Other _____

Patient advised of charges: ❑ Yes ❑ No ❑ N/A

❑ I prefer to pick up records **❑ I wish to review records (by appointment only)** **❑ Please mail**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. 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.
4. 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.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee.

The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent, except that such person may make a disclosure if federal or state law permits it.

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

_____ _____

Signature of Patient (must be signed if age 14 years or older for Psychiatric records) — Date (authorization will expire 6 months after date signed)

_____ _____

Signature of Parent/Guardian (if applicable) — Relationship to Patient

DOMINION HOSPITAL
2960 Sleepy Hollow Road
Falls Church, VA 22044
Phone: 703-531-6105 Fax: 703-531-6139

Patient Information/Label