

Please fax – 540-741-1622 or Mail to: Health Information Management, Attention: Release of Information, 1201 Sam Perry Blvd., Fredericksburg, VA 22401

I, _____ DOB ____/____/____ SSN ____/____/____
Address _____ City _____
State _____ Zip Code _____ Phone (____) _____

authorize Mary Washington Hospital to release the information specified below, in accordance with the laws of Commonwealth of Virginia, and MediCorp Health System policies, to the party identified below.

Name _____
Organization _____
Street Address _____
City, State, Zip Code _____

Information To Be Released

Physician's Progress Notes _____	Radiology Report _____
Final Discharge Summary _____	Consultation _____
Emergency Room Reports _____	Complete Chart* _____
History and Physical _____	Psychiatric Records* _____
Laboratory Results _____	Drug & Alcohol* _____
HIV records* _____	Other (please specify) _____

***Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.**

Dates of Service _____ to _____ Medical Record # _____

The purpose for the disclosure of the above information is:

- _____ Continuing Care
- _____ Personal use
- _____ At the request of the party identified above (select only if the patient is initiating this authorization)
- _____ Other (please describe other purpose) _____

Virginia law allows for copy charges consisting of the following: \$10.00 administrative fee PLUS \$0.50 per page for the first 50 pages and \$0.25 per page thereafter, and \$1.00 per page of microfilm/fiche. Per Virginia law, records will be furnished within 15 days of receipt of such request.

I hereby authorize, allow, and cause the release of information indicated above. No threat or other coercive measures have induced me to sign this form, and I do release MediCorp Health System from, and covenant not to sue MHS for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as: _____ (if none specified, this authorization will expire 6 months after the date specified below).

Patient Signature: _____ Date ____/____/____

Parent/Guardian/Patient Designee Signature: _____ Date ____/____/____

Authority of Individual Signing For Patient: _____



Authorization to Release Confidential Medical Information

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