



## \* All items with an asterisk are MANDATORY fields.

If label is not available, please complete:

Birth: \_\_\_\_\_ Record # \_

Medical

Patient Name: \_\_\_\_

Gender: ☐ Male ☐ Female

Date of

<b>★</b> Patient Name		Medical Record Number		
Social Security#		* Patient Date of Birth		
* Contact Phone Number				
* Patient Address				
	Street Address	City	State Zip Code	
* I authorize Inova to release or disclose the	e following information to:			
		cian □ Other		
	Phone #	(required if records are to be fax	ked)	
Name of person or entity to receive information	Fax # (25	5 pages or less)		
Name of person of entity to receive information				
Street Address	City	State	Zip Code	
* Information to be Released/Disclosed:				
☐ Complete Medical Record	Abstracts of Medical Record:		Other Records:	
Facility:	☐ Consultations	☐ Laboratory Reports	☐ Physician Orders	
Dates of admission/treatment requested:	☐ Discharge Summary	☐ Operative Reports	☐ Plan of Care	
☐ Billing Information	<ul><li>☐ EKG/EEGs</li><li>☐ Emergency Room Records</li></ul>	☐ Pathology Reports ☐ Radiology Reports	<ul><li>□ Progress Notes</li><li>□ Psychiatric Admit Note</li></ul>	
□ Other	□ Linergency Room Records	☐ History & Physical	☐ Psychiatric Evaluation	
			☐ Radiology Images/CD	
			☐ Other	
* Purpose:	* Record Disposition	n:		
☐ Medical Follow-Up		☐ Release to MyChart ☐ Expedited Delivery**		
☐ Attorney		☐ Please mail the records ☐ I will pick up the records ☐ Fax to the number above ☐ I wish to review the records		
☐ Personal Use	☐ Fax to the number a		will need to make an	
☐ Disability		,	intment for the review)	
☐ Insurance		**On request, Health Information Management can expedite record delivery. You will be billed		
☐ Other	for actual charges incu	for actual charges incurred.		
I understand if the person or agency that r				
privacy regulations, the information descril	bed above may be redisclose	ed and is no longer protec	ted by these regulations.	
I understand written notification is necessar	arv to cancel this authorization	on. I am aware that my car	ncellation will not be effective as to	
disclosures already made in reference to t		,		
I de cet have to story this force. To show the		Lala matakatan Hala fama		
I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.				
* Patient or Authorized Representative (signature)		* Date/Time (Authorization will expire six months after date signed)		
	•	•	,	
* Patient or Authorized Representative (print name)		★ Relationship to Patient		
	·			
PATIENT IDENTIFICATION	ON I			
		Inova		

inova

## **Authorization to Release/Disclose Protected Health Information**