FAUQUIER HEALTH

Patient Authorization for Disclosure of Health Information:

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I **request that my protected health information (PHI) from Fauquier Hospital be disclosed to:**
Recipient Name:_____
Address: _____ City: _____ State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

❑ Anesthesia	❑ Discharge Summary	❑ Imaging Reports	❑ Physician Orders	❑ All Records
❑ Billing Records	❑ EKG's	❑ Laboratory	❑ Outpatient Records	❑ Other _____
❑ UB04	❑ Emergency Records	❑ Medication Records	❑ Pathology Report	❑ _____
❑ Itemized Bills	❑ Face Sheet	❑ Nursing Records	❑ Progress Notes	❑ _____
❑ Consultation	❑ History & Physical	❑ Operative Report	❑ Accounting of Disclosures	

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. ***State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):***

Alcohol, Drug, or Substance Abuse Records □ Yes □ No | Dates: _____
HIV Testing and Results □ Yes □ No | Dates: _____
Mental Health □ Yes □ No | Dates: _____
Psychotherapy Records □ Yes □ No | Dates: _____
Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR** All past, present and future encounters/visits
Purpose for requesting information: (check one) □ Legal □ Insurance □ Personal □ Continuation of Care □ Other *(please specify):*
_____

Disclosure Format (paper is default if not marked): (check one) □ US Mail – paper format Fax (healthcare provider only)
□ E-mail (secure format) □ CD/Flash drive – secure format □ Other *(please specify):*
_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 500 Hospital Drive Warrenton, VA 20186 Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 1 year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

FOR OFFICE USE ONLY:

Verified :	Yes	No	License #		
By:			SS #		
Signature:	Yes	No	Other:		