

EVMS Medical Group

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize and request

Department/Division/Physician
Street
City, State, Zip

to release copies of my complete medical record (It is our policy the last two years of medical records will be forwarded, unless specified otherwise. If more information is needed, you may contact our office.) I understand that all of the information contained in my medical record will be released including information relating to psychiatric treatment or treatment relating to drug or alcohol abuse and HIV/AIDS testing or treatment except as specifically listed as follows,

or
specific medical information to include
concerning my health management, illnesses and/or treatment during the period from to

*If any information appears on this line DO NOT send this form with the medical record.

to:
Physician/Hospital/Other
Street
City, State, Zip

This authorization shall remain valid for 90 days. I understand that I may revoke this authorization at any time, but revocation is not effective for disclosures made prior to the revocation. I understand that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this authorization shall be included with my original records. I understand that if my medical information is disclosed to someone who is not required to comply with federal privacy regulations, than such information may be redisclosed and would no longer be protected. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Eastern Virginia Medical School Medical Group unless that treatment is tied to a research related treatment.

Patient Name DOB

Address

Signature Date Witness Date
patient/parent/guardian (not required)

Personal Representative name signature date

Authority of Personal Representative:

Information to be: Mailed Disposition: Mailed
Picked up by patient Picked up by Patient
Transmitted electronically Transmitted electronically