Richmond Health Information Management Service Center (HSC) Release of Information
7300 Beaufont Springs Drive, Richmond, VA 23225
Phone: 804-267-2103 Toll Free: 877-302-7338

Instructions for Completing the AUTHORIZATION FORM

These instructions were designed to help answer any questions that may arise when completing the *Authorization Form for the Release of Protected Health Information*.

Section A

Patient's Name:	The name of the person who received the medical service(s).
Birth Date:	The patient's date of birth.
Patient's Phone:	A phone number where the patient may be reached.
Social Security Number:	Last four digits of SSN – ***This field is optional***.
Provider's Name:	Name of the facility or hospital where the patient service was performed.
Provider's Address:	Complete Mailing Address of the facility or hospital – ***This field is optional.***
Recipient's Name:	Name of the person being authorized by the patient to receive the requested protected health information.
Recipient's Phone:	A phone number where the recipient of the medical information can be reached.
Recipient's Address:	Complete Mailing Address for the designated "Recipient".
Email:	Complete ONLY if Email delivery is requested.
Request Delivery:	Specifiy how the recipient is to receive requested information.
Expiration Date or Event:	Authorization will expire in 90 days unless otherwise noted.
Purpose of Disclosure:	Explain why the requested protected health information is being used or disclosed.
Psychotherapy Notes:	Mark the "Yes" box if the information being requested is Psychotherapy related. Mark the "No" box if the information does not relate to Psychotherapy.

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Description of Information to be Used or Disclosed:

Description:	Mark the box that best describes the type of health information being requested for use or disclosure. Most of these items relate to specific medical provider records. ***There is a fee ($0.25 per page) so please only request the documents that are necessary to avoid additional charges.**
Date of Service*:*	Provide the date of service when the medical treatment was rendered. If the information being requested pertains to an inpatient hospital stay, provide the discharge date. If a copy of a billing statement is being requested, you can specify the statement date.
Consent to Release*:*	Initial this box if you acknowledge and consent to the release of information that may contain alcohol/drug abuse, psychartriac, HIV testing, HIV results or AIDS information. Check box to right if not applicable.

Section B

This section needs to be completed only if the request is for marketing purposes (and) the patient received compensation in exchange for using or disclosing this information. Select Yes (or) No. If yes, provide a brief explanation.

Section C – Required Signatures

Signature of Patient/Guardian (or) Personal Representative:	The patient's signature is always required, unless the patient is a minor (or) a legal representative has been appointed**.**
Date Signed:	Provide the date that the authorization form was signed.
Printed Name of Patient/Guardian (or) Personal Representative:	Print the name of the individual who signed the authorization form.
Relationship of Personal Representative to Patient:	If someone other than the patient signs the authorization form, a description of the representative's authority to act on behalf of the patient must be provided. (e.g. Power of Attorney, Trustee, Conservator, Executor of Estate, or Legal Guardian)

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Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**		
Patient's Phone:	**Last 4 digit SSN *(optional)*:**		
Provider's Name:	**Recipient's Name:**		
	Recipient's Phone:		
Provider's Address:	**Address:**		
Email (If email checked below. Please print legibly):	**City:**	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐**FAX**_____ ☐ **Email** ___ **NOTE: In the event the facility is unable to provide an electronic delivery as requested, an alternative delivery method will be provided (e.g. paper copy).**

This authorization will expire ninety days from the date of signature unless otherwise indicated below.

Date: **Event:**

Purpose of disclosure:

Is this request for psychotherapy notes? □ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. □ No, then you may check as many items below as you need.

Description of information to be used or disclosed

Description: check all that apply	Date(s):	Description: Description: check all that apply	Date(s):	Description: check all that apply	Date(s):
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer Forms ☐ ER Information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-04: ☐ Other: ☐ Other:	

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 effect 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 re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is this request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete section B, otherwise skip to signature section below.

Will the recipient receive financial or in-kind compensation in exchange for disclosing information? □ Yes □ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? □ Yes □ No

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

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient/Representative:	**Relationship to Patient:**
ROI updated 02/12/14	

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