Virginia Ear, Nose & Throat

Authorization for Release of Health Information

Patient Name: _____ **Patient #:** _____

Date of Birth: _____ **Physician's Name:** _____

I hereby request that Virginia Ear, Nose & Throat Associates (**check one only**):

☐ Provide a copy of my health information **to me** (please initial) _____ paper format or _____ electronic format

☐ Release my health information **to** (specify below) (please initial) _____ paper format or _____ electronic format

☐ Request copies of my health information **from** (specify below)

_____ _____
(name of person or entity) (fax number)

_____
(street address) (City) (State) (Zip Code)

Please include information for the following dates of service _____ (information for all dates of service will be included if left blank)

_____ Please initial here if you would like to **exclude** records from other healthcare providers

The purpose for this request is:

☐ At my request ☐ For my healthcare/treatment ☐ For legal purposes ☐ For payment/insurance purposes

This authorization is valid for one year or until _____, unless I notify Virginia ENT in writing that it is rescinded sooner.
(insert date)

I understand that I have the right to access my health information in accordance with Federal and State regulations and the policies of Virginia ENT. I also understand that Virginia ENT may charge me for copies and I have been informed of the fee schedule.

I understand that Virginia ENT has the right to deny me access to my health information in certain circumstances in accordance with Federal and/or State regulations. If access is denied I understand that the reason for the denial will be given to me in writing and it will describe whether I have the right to have the denial reviewed by a Licensed Healthcare Professional.

_____ _____
Patient or Legal Representative Date

_____
Relationship of Legal Representative to Patient

Phone: 804-484-3700 **West End Fax:** 804-282-5431 **Southside Fax:** 804-323-0770

www.virginiaent.com

Instructions for Completing the Authorization for Release of Health Information

Following is our Authorization for Release of Health Information. This form may be used to request release of your health information:

- To you,
- To someone other than you (e.g., another doctor), or
- **FROM** another provider to be sent to Virginia ENT

This form may only be used to make one request. If you have more than one request (e.g., you want records for yourself AND you want them sent to another provider) you will need to complete two separate forms.

If you have any questions about completing the form please contact our Medical Record staff at 804-484-3700 ext 2012.