

**AUTHORIZATION TO RELEASE CONFIDENTIAL  
HEALTH RECORDS**

**IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT  
OF 1996 (HIPAA)<sup>i</sup> AND THE VIRGINIA HEALTH RECORDS PRIVACY ACT<sup>ii</sup>**

**TO:**

\_\_\_\_\_  
Name or other identification of specific health care entity

\_\_\_\_\_  
Address of health care entity

\_\_\_\_\_  
Telephone number (optional)

\_\_\_\_\_  
Fax number (optional)

\_\_\_\_\_  
E-Mail address (optional)

\_\_\_\_\_  
Purpose of the disclosure of the health care records or information **or** at the request of the individual<sup>iii</sup>.

**DOCTOR OR HEALTH CARE ENTITY:** You must comply with this request within **15 days of receipt<sup>iv</sup>** of this Authorization. A copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with the individual's original records.

**INDIVIDUAL:**

\_\_\_\_\_  
Individual's name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address/City/State/Zip Code

\_\_\_\_\_  
Social Security Number (optional)

\_\_\_\_\_  
Name of doctor or the health care entity

is required by law to protect my health records or information.

By signing this Authorization I give permission to:

\_\_\_\_\_  
Name of doctor or the health care entity

to use and or disclose (release) my health records or information to

\_\_\_\_\_  
Person, agency, or health care entity (recipient) to whom information or health records is to be disclosed (released)

\_\_\_\_\_  
Address

The information to be disclosed (released)<sup>v</sup> is

\_\_\_\_\_  
Information or health records to be disclosed (released)

I understand that:

- a. Health records and information disclosed under this Authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely (only) in the possession (control) of the health care entity.
- b. The health care entity may not condition treatment or payment on my willingness to sign this Authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this Authorization.
- c. I can change your mind and revoke (take back) this Authorization at any time, but my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records that were already disclosed under the Authorization.

To revoke this Authorization, I must write to:

\_\_\_\_\_  
Name of health care entity

\_\_\_\_\_  
Address of health care entity

This Authorization expires on \_\_\_\_\_  
Date or event

\_\_\_\_\_  
Printed name of individual or individual's legal representative

\_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Signature of individual or individual's legal representative if individual is unable to sign

\_\_\_\_\_  
Relationship or authority of legal representative

**THE HEALTH CARE ENTITY SHALL ACCEPT A PHOTOCOPY, FACSIMILE OR OTHER COPY OF THE ORIGINAL, SIGNED BY THE REQUESTER, AS IF IT WERE AN ORIGINAL.**

<sup>i</sup> 42 U.S.C. § 1320d et seq.

<sup>ii</sup> Va. Code § [32.1-127.1:03](#)

<sup>iii</sup> An individual is a patient who is receiving or has received health services from a health care entity

<sup>iv</sup> Va. Code § 32.1-127.1:03(E)

<sup>v</sup> Va. Code § 32.1-127.1:03(B) "Health record" means any written, printed or electronically recorded material maintained by health care entity in the course of providing health services to an individual concerning the individual and the services provided. Health record also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual."