

**NOTICE OF OBJECTION BY HEALTH CARE ENTITY
TO RELEASE OF CONFIDENTIAL HEALTH RECORDSⁱ**

On _____, _____
Date Name of doctor or health care entity

Address doctor or health care entity Telephone number (optional)

received an **Authorization to Release Confidential Health Records**, from

_____ signed by
Individual, agency or health care entity to whom disclosure (release) is to be made

Individual's name and address who signed the Authorization to Release Confidential Health Records

Date of birth Social Security Number (optional) Other identifying information (optional)

I. RESPONSE:ⁱⁱ

- A.** The information requested:
does not exist or cannot be found;
is not maintained by the above health care entity; **[or]**
may be available from:

Name and address

- B.** The individual or requester has not established her/his/its authority to receive the records or proof of her/his/its:
identity, **[or]**
as otherwise provided by law.

II. RESPONSE REGARDING RESTRICTED RECORDSⁱⁱⁱ:

A determination has been made by _____
Name of doctor or clinical psychologist
that release of the requested records would be injurious to the individual's health.

See Va. Code § [32.1-127.1:03\(F\)](#) for right of individual to have a qualified physician or clinical psychologist authorize release of restricted records.

Date sent to requester or individual Signature of doctor or health care entity or representative

ⁱ Va. Code § [32.1-127.1:03](#) (amendments effective March 12, 2004)

ⁱⁱ Va. Code § 32.1-127.1:03(E)

ⁱⁱⁱ Va. Code § 32.1-127.1:03(F)