

## Virginia Interventional and Vascular Associates (VIVA)

6600 West Broad Street, Suite 200 · Richmond, VA 23230 Phone: 804-486-4625 Fax: 804-918-7986

### AUTHORIZATION TO INSPECT, COPY OR RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
[Please Print Full Name]

Last 4 of SOCIAL SECURITY NUMBER: \_\_\_\_\_ DAY PHONE: \_\_\_\_\_

Patient Address: STREET: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
[Need Complete Address to be Valid]

Authorize: \_\_\_\_\_  
[Name of organization or physician to release medical records from]

Date(s) of Service to be Released: \_\_\_\_\_

#### Information Requested: (Select from options below)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Entire Record      | <input type="checkbox"/> Pathology Reports           | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> X-rays or Imaging Report(s) |   |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Other (be specific): _____  |   |

#### Method of Release:

Facility/Provider/Person to Receive Information: \_\_\_\_\_  
[Name of Facility/Provider/Person to Disclose Health Information to]

Mailed to: STREET: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
[Need Complete Mailing Address to be Valid] [May take 7 to 10 business days]

or  eDelivered by Ciox Health (Nucleus) to patient email address (records and imaging): \_\_\_\_\_

[Please Provide Patient Email Address if Requesting Electronic Delivery] [May take 3 to 5 business days] PRINT EMAIL ADDRESS

#### Purpose of Disclosure:

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Continuity of Care       | <input type="checkbox"/> Insurance | <input type="checkbox"/> Litigation                    | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal  | <input type="checkbox"/> Other (Please specify): _____ |  |

**Fees: I understand that copying charges may be applied according to State/Federal Law. If so, you will be billed by Ciox Health.**

#### Authorization to Release Information:

1. I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse unless otherwise specified below in Special Instructions:

Special Instructions, if any: \_\_\_\_\_

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the facility/provider listed above.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility/provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire 90 days from the date of signature. If applicable, insert another date or event of expiration:** \_\_\_\_\_.

4. I may request a copy of this authorization form.

Signature of Patient or Legal Representative \_\_\_\_\_ DATE: \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_

[Please Provide Medical Power of Attorney if Individual is Over the Age of 18 and Not Signing this Authorization]

OVER

**Department Use Only**

Verified identity using:  Driver's License  Work/Gov't ID  In person  Patient Portal

Entered in Medical Records Log: \_\_\_\_\_

Processed By: \_\_\_\_\_

Date Processed: \_\_\_\_\_

Pages Released: \_\_\_\_\_

eRequest ID: \_\_\_\_\_