5-Hole 1/4 1 3/8 c-to-c

BON SECOURS
RICHMOND HEALTH SYSTEM
Bon Secours Richmond Health System

Place patient label inside box (if no patient label, complete below)
Name: ______________________
DOB: ______________________
MR #: ______________________

☐ Memorial Regional Medical Center
8260 Atlee Road,Mechanicsville, VA 23116
Tel: 804-764-6427 Fax: 804-764-6324

☐ Richmond Community Hospital
1500 North 28th Street, Richmond, VA23223
Tel: 804-225-1778 Fax: 804-225-7359

☐ St. Mary's Hospital
5801 Bremo Road, Richmond, Va. 23226
Tel: 804-281-8135 Fax: 804-673-9561

☐ St. Francis Medical Center
13710 St. Francis Blvd.
Midlothian, VA 23114
Tel: 804-594-7850 Fax: 804-594-7854

☐ Care-A-Van
4121 Cox Road, Suite 110
Glen Allen, VA 23060
Tel: 804-545-1920 Fax: 804-545-1935

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:______________________________ DATE OF BIRTH:______________
[Please print full name]

SOCIAL SECURITY NUMBER:______________________________ DAY PHONE:______________

INFORMATION REQUESTED:

☐ Immunization Record
☐ Most recent history & physical
☐ Most recent discharge summary
☐ Consultation (please supply doctor's name) ______________
☐ Abstract of Record (D/C Summary, H&P, Operative Report, Consultation, Lab, Radiology, EKG)
☐ X-ray or Imaging Reports from_________ (date) to_________ (date)
☐ Laboratory results from_________ (date) to_________ (date)
☐ Entire record
☐ Other [please specify] ______________________________

☐ _______ (INITIALS) I understand that the information in my health record may include information relating to sexually transmitted disease, 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.

PERSON/FACILITY TO RECEIVE INFORMATION:______________________________

ADDRESS:______________________________

This information is being disclosed for the following purpose(s):______________________________

AUTHORIZATION TO RELEASE INFORMATION

1. 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. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. 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 number above.
2. 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 checked 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 on the following date, event, or condition:______________________________ . If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
3. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative______________________________
DATE

If signed by legal representative, relationship to patient:______________________________

SIGNATURE OF WITNESS______________________________
DATE

DEPARTMENT USE ONLY

PROCESSED BY:______________________________ DATE PROCESSED:______________

☐ IDENTITY VERIFIED ☐ SIGNATURE VERIFIED

INFORMATION SENT/PROVIDED:______________________________