Sentara Authorization to Disclose Protected Health Information

Patient Name: ______________________ SSN / Medical Record Number: ______________________

Date of Birth: ______________________ Daytime Phone Number: ______________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

____

Address: ______________________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

__ problem list
__ medication list
__ list of allergies
__ immunization record
__ most recent history and physical
__ most recent discharge summary
__ laboratory results from (date) __________ to (date) __________
__ x-ray and imaging reports from (date) __________ to (date) __________
__ consultation reports from (doctors' names) ______________________
__ Designated record set.
Other ______________________

____

4. 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.

5. This information may be disclosed to and used by the following individual or organization:

____

Address: ______________________

for the purpose of ______________________

6. I understand that I have a right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. 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 (6) months.

7. 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. Complete if Sentara requested the disclosure (circle appropriate will or will not)

Sentara will/ will not receive renurmeration for this disclosure

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 Sentara Privacy Contact. 757-857-8494

______________________ ______________________

Signature of Patient or Legal Representative Date

______________________ ______________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

For [illegible] Use

Date Received: __________ Date Information Disclosed: __________ Record # __________

Person/Department Sending Records: ______________________

Original – Chart, 2nd copy to patient when requested

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.