EVMS Medical Group

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize and request :

EVMS/ Jones Institute for Reproductive Medicine
601 Colley Ave., Norfolk, VA 23507

to release copies of my **complete medical record** (It is our policy that the last two years of medical records will be forwarded, unless specified otherwise. If more information is needed, you may contact our office.) I understand that all of the information contained in my medical record will be released **including information relating to psychiatric treatment or treatment relating to drug or alcohol abuse and HIV/AIDS testing or treatment** except as specifically listed as follows:_____
_____*
or **specific medical information** to include _____
_____concerning my health management, illnesses and/or treatment during the period from _____ to _____.

***If any information appears on this line DO NOT send this form with the medical record.**

to:

Physician/Hospital/Other: _____
Street, City, State, Zip: _____

This authorization shall remain valid for 90 days. I understand that I may revoke this authorization at any time, but revocation is not effective for disclosures made prior to the revocation. I understand that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this authorization shall be included with my original records. I understand that if my medical information is disclosed to someone who is not required to comply with federal privacy regulations, than such information may be redisclosed and would no longer be protected. I understand that I do not have to sign this authorization and that my refusal to sign will not effect my ability to obtain treatment from Eastern Virginia Medical School Medical Group unless that treatment is tied to a research related treatment.

Patient Name_____DOB_____

Address_____ SSN_____

Signature _____Date _____ Witness _____Date _____
patient/parent/guardian *(not required)*

Personal Representative _____
name *signature* *date*

Authority of Personal Representative:_____

Information to be: ☐ Mailed
☐ Picked up by patient
☐ Transmitted electronically

Disposition: ☐ Mailed
☐ Picked up by Patient
☐ Transmitted electronically

Revised 4/2013