INOVA

1ROI

* All items with an asterisk are MANDATORY fields.

Do NOT use for CATS releases

A

* Patient Name _____ Medical Record Number _____
* Patient Date of Birth _____ Social Security# (last 4 digits) _____
* Contact Phone Number _____ Contact Email _____
* Patient Address _____
Street Address City State Zip Code

B * **I authorize Inova to** (check one):

☐ **Release** the information indicated to:
☐ **Request** the information indicated from:

_____
Name of person or entity to receive or disclose information

_____
Street Address City State Zip Code

Phone# _____ Fax# _____ Email _____

C * **Information to be Released/Disclosed:**

Facility: _____
☐ All Inova facilities

Dates of admission/treatment requested:
_____
_____
_____

(**check all that apply**):

☐ Billing Information
☐ Complete Medical Record
☐ Consultations
☐ Discharge Summary
☐ EKG/EEGs
☐ Emergency Room Records
☐ History & Physical
☐ Laboratory Reports
☐ Medication List
☐ Operative Reports
☐ Pathology Reports
☐ Physician Orders
☐ Progress Notes
☐ Psychiatric Admit Note
☐ Psychiatric Evaluation
☐ Radiology Images/CD
☐ Radiology Reports
☐ Other (specify):
_____
_____

D * **Purpose** (check all that apply):

☐ Medical Follow-Up
☐ Attorney
☐ Personal Use
☐ Disability
☐ Insurance
☐ Other _____

E * **Provide Record by Means of** (check one):

☐ MyChart
☐ Fax (25 pages or less)
☐ Electronic Media (CD)
☐ Mail – Regular
☐ Mail – Expedited. On request, Health Information Management can expedite record delivery. You will be billed for actual charges incurred.
☐ In Person Review. You will need to make an appointment for the review.
☐ Email – Encrypted
☐ Email – Unencrypted
☐ Pick-up

F I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that this disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.

I understand treatment will still be provided to me if I do not sign this form.

_____ _____
* **Patient or Authorized Representative** (signature) * Date/Time (Authorization will expire six months after date signed)

_____ _____ ☐ Self
* **Patient or Authorized Representative** (print name) * Relationship to Patient (specify, or check box if "self")

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova
Authorization to Request/Disclose Protected Health Information