

Shenandoah Women's HealthCare  
240 Lucy Drive  
Harrisonburg, Va 22801  
Phone 540-438-1314 Fax 540-438-0797

**Authorization for Disclosure of Health Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The individual or organization below is authorized to release my records:  
(Doctors Office)  
Name of Individual/Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
3. The type and amount of information to be used or disclosed is as follows:  
(include dates where appropriate).  
\_\_\_\_\_ Complete health records          \_\_\_\_\_ x-ray reports  
\_\_\_\_\_ other (please specify) \_\_\_\_\_          \_\_\_\_\_ Physician Notes
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 released to myself or the following individual or organization. (who is receiving records)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
For the purpose of: Referral to Specialist \_\_\_\_\_ Leaving the Practice: \_\_\_\_\_ Moving Out of the area: \_\_\_\_\_  
Personal Use (another physician) \_\_\_\_\_ Other Reason: \_\_\_\_\_
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical record contact person. 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: \_\_\_\_\_
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. 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 assure 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 re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of Witness

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

For office Use Only: Date Received \_\_\_\_\_ Date Records

Released: \_\_\_\_\_ Page Count \_\_\_\_\_ Cancelled All Future

Appts: \_\_\_\_\_ Initials: \_\_\_\_\_

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701-243) and federal law 42 CFR, Part II.