LIBERTY UNIVERSITY | HEALTH CENTER

Services by: cvfp

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

*Patient Name: _____ *Date of Birth: _____
[Please print full name]
*Social Security Number: _____ *Day Phone: _____

*Patient Address: Street: _____ City: _____ State: ____ Zip: _____

*Authorize: _____
(Name of Facility/Provider to Disclose Health Information)

Information Requested: (Select from options below)

*Date(s) of Service Requested: _____

- ☐ Office Visit Notes
- ☐ Entire Record
- ☐ Laboratory Results
- ☐ Pathology Reports
- ☐ X-rays or Imaging Report(s)
- ☐ Other (be specific): _____
- ☐ Immunization Records

*Person/Facility to Receive Information : _____

☐ Mailed to: Street: _____ City: _____ State: ____ Zip: _____

☐ **Phone**:_____ ☐ **Fax**: _____

☐ eDelivered by Healthport to patient email address only: _____

*Purpose of Disclosure:

- ☐ Continuity of Care
- ☐ Disability Determination
- ☐ Insurance
- ☐ Personal
- ☐ Litigation
- ☐ Other (Please specify): _____
- ☐ Worker's Compensation

Authorization to Release Information:

1. I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, 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. Special Instructions, if any: _____

2. 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, payment, enrollment in a health plan, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. 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 Central Virginia Family Physicians, Inc at the facility listed above.

3. 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 listed 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 90 days from the date of signature. If applicable, insert another date or event of expiration:
_____

4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that copying charges will be applied according to State/Federal Law.

Signature of Patient or Legal Representative _____ Date

If signed by legal representative, relationship to patient: _____

Department Use Only

Processed By: _____ Date Processed: _____

Pages Released: _____ eSmartlog ID: _____