VCU Medical Center

Virginia Commonwealth University

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

(Please fill in highlighted areas)

Healthcare Provider, Hospital, or Agency Information is to be OBTAINED FROM:

Name of Doctor/Hospital_____

Address_____

City_____State_____Zip Code_____

Phone Number_____

Patient for Whom Information is to be Obtained:

Patient Name: _____Date of Birth: _____

S.S.#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____Work Telephone Number: _____

Person or Agency to whom disclosure is to be RELEASED TO:

Dr. _____
VCU Medical Center Department of Neurosurgery
PO Box 980631
417 N. 11th Street, ACC 6th Floor
Richmond, VA 23298-0631
Fax: 804-828-0374

As the person signing this authorization, I understand that I am giving my permission to VCU/MCV Neurosurgery for disclosure of confidential medical records to include, applicable, PSYCHIATRIC, DRUG/ALCOHOL, HIV, the virus which causes Acquired Immune Deficiency Syndrome (AIDS), Hepatitis B or C viruses, testing/treating, and/or other information contained in the medical record, unless indicated otherwise in the following "Special Instructions".

Special Instructions:_____

I also understand that I have the right to revoke this authorization, but that my revocation is not effective until delivered in writing to the person who is in possession of my medical records. A copy of this revocation shall be filed in my original records; also a copy of the authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this authorization pertains may not re-disclose them to anyone else without my separate written authorization, unless such a recipient is a provider who makes a disclosure permitted by law.

_____ _____

Signature of Patient or Guardian/Next of Kin Date