HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code | **Any Other Names Used**

I hereby request that Privia Medical Group use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all):

   _____

2. Be sent to the following person / entity at the address listed:

   _____

   Name

   _____

   Address

   _____

   City, State Zip Code

3. I authorize disclosure of the following specific information (include dates of service):

   _____

   _____

   _____

NOTE: UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: ☐ YES, PLEASE DISCLOSE THIS INFORMATION: _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless otherwise specified below, I understand that my PHI will be provided in paper format.** I hereby request that my PHI be provided in the following format:
   ☐ on an encrypted USB drive ☐ on an unencrypted USB drive ☐ other (please specify) _____
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
6. I understand I may revoke this authorization by notifying Privia Medical Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____.
8. This authorization expires on _____ ____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ | _____ | _____
Signature of Patient | **Date of Patient's Signature** | **Patient's Date of Birth**

_____ | _____ | _____
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate | **Date of Legal Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

For Privia Use Only

Date Received | **Date Processed** | **Format** | **Fee** | **Pt Notified of Fee** | **Medical Record #**

0517