

**HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION**

<hr/> <b>Patient's Full Name</b>	<hr/> <b>Patient's Date of Birth</b>
<hr/> <b>Address</b>	<hr/> <b>Patient's Telephone Number</b>
<hr/> <b>City, State Zip Code</b>	<hr/> <b>Any Other Names Used</b>

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

- From the following Care Center locations and/or providers (list all):  
\_\_\_\_\_
- Be sent to the following person / entity at the address listed:  

_____
<b>Name</b>
_____
<b>Address</b>
_____
<b>City, State Zip Code</b>
- 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: \_\_\_\_\_

- 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) \_\_\_\_\_
- 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.
- 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.
- My purpose/use of the information is for  personal use; or  other (please specify) \_\_\_\_\_.
- 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.**

<hr/> <b>Signature of Patient</b>	<hr/> <b>Date of Patient's Signature</b>	<hr/> <b>Patient's Date of Birth</b>
<hr/> <b>If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate</b>	<hr/> <b>Date of Legal Guardian's/Personal Representative's Signature</b>	<hr/> <b>Description of Authority to Act for the Individual</b>

For Privia Use Only

<hr/> <b>Date Received</b>	<hr/> <b>Date Processed</b>	<hr/> <b>Format</b>	<hr/> <b>Fee</b>	<hr/> <b>Pt Notified of Fee</b>	<hr/> <b>Medical Record #</b>
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