Fill out the information below and mail to: Mary Washington Healthcare Health Information Management Department, 2300 Fall Hill Avenue, Suite 101, Fredericksburg, VA 22401 or fax to: (540) 741-1622

I authorize the following Mary Washington Healthcare Facility(s):_____

☐ To release the information from the record of: ☐ To obtain records from_____on:

Patient Name:_____ Social Security Number:_____

Date of Birth:_____ Daytime Phone Number:_____

Address:_____

Documentation can be released electronically if stored in an electronic media.

Preferred media: ☐ Paper ☐ CD ☐ Online Record eDelivery email address:_____

Dates of Service: _____ to _____

Information to be Released:

☐ History & Physical Exam	☐ Discharge Summary	☐ Emergency Department Report
☐ Consultation Report	☐ Operative Report	☐ Pathology Report
☐ Physician Progress Notes	☐ Laboratory Report	☐ Radiology/Imaging Report ☐Images
☐ EKG Report	☐ Psychiatric Record*	☐ HIV Records*
☐ Drug & Alcohol*	☐ Complete Chart*	☐ Advance Directive (any date of service)
☐ DNR (any date of service)	☐ Billing	☐ Other:_____

***Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.**

Person/Facility to Receive Information:_____

Street:_____ City:_____ State:_____ Zip Code: _____

This information is being disclosed for the following purpose:_____

Authorization to Release Information:

1. 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. 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 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 the Health Information Management Department at (540) 741-1620.
2. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as:_____(if none specified, this authorization will expire 6 months after the date specified below).
3. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied.

Signature of Patient or Legal Representative: _____ Date:_____

☐ Parent or Legal Guardian ☐ Medical Power of Attorney ☐ Next of Kin Deceased ☐ Executor of Estate

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Department Use Only

MRN_____ ID Verified (Type and ID#)_____

Processed By: _____ Date Processed:_____ Pages Provided:_____

R05805

Mary Washington Healthcare

☐ **Mary Washington Hospital**

☐ **Stafford Hospital**

Authorization to Release Confidential Medical Information

FR-1088-MWHC Rev. 5/2023 Top Copy: Medical Records Bottom Copy: Patient

Patient Identification