Virginia Department of Health
Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

DISCLOSURE AUTHORIZATION **Name:**_____ **DOB:** ___/__/____

As the person signing this authorization, I understand that:

- The provision of treatment or payment cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by a recipient may no longer be protected by this authorization.
- The original or copy of the authorization shall be included in my medical record.
- I have a right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.

❑ I do **not** authorize disclosure of my health information to anyone, other than for treatment, payment and health care operations

I am authorizing _____ (health department) to disclose my health information to the following organization(s) or person(s) specified below:

Beginning Date	Expiration Date	Organization(s) or Person(s)	Purpose for Disclosure	Information to be Disclosed	Date Rescinded (by VDH Staff)	Rescinded by (Staff Initials)

This information may be disclosed immediately.

PERSONAL CARE REPRESENTATIVE

❑ I do not authorize anyone to act as my personal representative

❑ I authorize you to discuss my health information with the following individual(s) acting as my personal care representative:

Name and Relationship of Personal Care Representative:	

ALTERNATIVE METHOD OF CONTACT

❑ I do not wish to be contacted in any way other than my home address and/or phone number..

❑ I prefer that you contact me in a way other than my home address and/or phone number. I wish to be contacted in the following manner:

Alternative Contact Information:	

_____ _____

Print Name Date

_____ _____

Signature Relationship to Patient

This form must be reviewed with the patient at least annually:

Date Reviewed	Staff Initials

This form must be filed in the medical record. A copy of this authorization is available to the patient upon request . 4//14 03 Rev'sd 2011