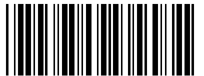
Inova™



* All items with an asterisk are MANDATORY fields.

Do NOT use for CATS releases

A

* Patient Name ______________________ Medical Record Number ______________________
* Patient Date of Birth ______________________ * Contact Phone Number ______________________
Contact Email ____
* Patient Address ____
Street Address City State Zip Code

B

* **I authorize Inova to** (check one):
☐ **Release** the information indicated to:
☐ **Request** the information indicated from:
____
Name of person or entity to receive or disclose information

____
Street Address City State Zip Code

Phone# ______________ Fax# ______________ Email ______________________

C

* **Information to be Released/Disclosed:**
Facility: ______________________
☐ All Inova facilities
Dates of Service:
____
____
____

(**check all that apply):**
☐ Billing Information
☐ Complete Medical Record
☐ Consultations
☐ Discharge Summary
☐ EKG/EEGs
☐ Emergency Room Records
☐ History & Physical
☐ Laboratory Reports
☐ Medication List
☐ Operative Reports
☐ Pathology Reports
☐ Physician Orders
☐ Progress Notes
☐ Psychiatric Admit Note
☐ Psychiatric Evaluation
☐ Radiology Images/CD
☐ Radiology Reports
☐ Other (specify):
____
____

D

* **Purpose** (check all that apply):
☐ Medical Follow-Up
☐ Attorney
☐ Personal Use
☐ Disability
☐ Insurance
☐ Other ______________________

E

* **Provide Record by Means of** (check one):
☐ MyChart
☐ Fax (25 pages or less)
☐ Electronic Media (CD/Thumbdrive)
☐ Mail – Regular
☐ Mail – Expedited. On request, Health Information Management can expedite record delivery. You will be billed for actual charges incurred.
☐ In Person Review. You will need to make an appointment for the review.
☐ Email – Encrypted
☐ Email – Unencrypted
☐ Pick-up

F

I understand that:
- If the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
- Written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
- This disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.
- Treatment will still be provided to me if I do not sign this form.
- This authorization will expire six (6) months after the date signed.

______________________________ ______________________________
* **Patient or Authorized Representative** (signature) * Date/Time (Authorization will expire six months after date signed)

______________________________ ______________________________ ☐ Self
* **Patient or Authorized Representative** (print name) * Relationship to Patient (specify, or check box if "self")

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________
Date of Birth: ______________ Medical Record # ______________
Gender: ☐ Male ☐ Female

Inova
Authorization to Request/Disclose Protected Health Information

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

CAT # 31247 / R091923 • PADS OF 100