



**BON SECOURS  
RICHMOND HEALTH SYSTEM**  
Bon Secours Richmond Health System



Place patient label inside box (if no patient label, complete below)

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
MR #: \_\_\_\_\_

Memorial Regional Medical Center  
8260 Atlee Road, Mechanicsville, VA 23116  
Tel: 804-764-6427 Fax: 804-764-6324  
 Richmond Community Hospital  
1500 North 28th Street, Richmond, VA 23223  
Tel: 804-225-1778 Fax: 804-225-7359  
 St. Mary's Hospital  
5801 Bremono Road, Richmond, Va. 23226  
Tel: 804-281-8135 Fax: 804-673-9561

St. Francis Medical Center  
Mailing Address  
13710 St. Francis Blvd.  
Midlothian, VA 23114  
Tel: 804-285-6868 Fax: 804-594-7858  
 Care-A-Van  
4121 Cox Road, Suite 110  
Glen Allen, VA 23060  
Tel: 804-545-1920 Fax: 804-545-1935

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
[Please print full name]  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DAY PHONE: \_\_\_\_\_

**INFORMATION REQUESTED:**

- Immunization Record  Most recent discharge summary  Consultation (please supply doctor's name) \_\_\_\_\_
- Most recent history & physical  Abstract of Record (D/C Summary, H&P, Operative Report, Consultation, Lab, Radiology, EKG)
- X-ray or Imaging Reports from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)
- Laboratory results from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)
- Entire record  Other [please specify] \_\_\_\_\_

\_\_\_\_\_ (INITIALS) I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

PERSON/FACILITY TO RECEIVE INFORMATION: \_\_\_\_\_  
STREET: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

This information is being disclosed for the following purpose(s): \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

- 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 number above.
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility checked above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
- I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative \_\_\_\_\_ DATE \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_

SIGNATURE OF WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

**DEPARTMENT USE ONLY**

PROCESSED BY: \_\_\_\_\_ DATE PROCESSED: \_\_\_\_\_

IDENTITY VERIFIED  SIGNATURE VERIFIED

INFORMATION SENT/PROVIDED: \_\_\_\_\_



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