



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



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: 804-639-5193

Care-A-Van
4121 Cox Road, Suite 110
Glen Allen, VA 23060
Tel: 804-545-1920 Fax: 804-545-1935

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

Name: _____
DOB: _____
MR #: _____

Bon Secours HealthSource
Tel: 804-281-0201

Bon Secours Medical Group
Tel: 804-281-0248

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

INFORMATION REQUESTED:

- Access to MyChart 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) Immunization Record _____
- 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: _____