



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

- Memorial Regional Medical Center
- Richmond Community Hospital
- St. Francis Medical Center
- St. Mary's Hospital
- Bon Secours Medical Group
- Bon Secours HealthSource
- Care-A-Van

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

Name: _____

DOB: _____

MR #: _____

REQUEST TO HEALTH CARE PROVIDER FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

MEDICAL RECORD NUMBER: _____

DAY PHONE: _____

INFORMATION TO BE DISCLOSED:

- Immunization Record
- Most recent history & physical
- X-ray or Imaging Reports from _____ (date) to _____ (date)
- Laboratory results from _____ (date) to _____ (date)
- Entire record
- Most recent discharge summary
- Abstract of Record
- Other [please specify] _____
- Office visits
- Consultation (please supply doctor's name _____)
- Diagnostic test results

_____ (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: _____

ADDRESS: _____

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

AUTHORIZATION TO DISCLOSE

- 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 my Physician/Provider Authorized to Disclose Health Information.
- 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 Bon Secours entity requesting disclosure. 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 Bon Secours policy.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ Date _____ Time _____

If signed by legal representative, relationship to patient: _____

SIGNATURE/WITNESSES: _____ Date _____ Time _____

DEPARTMENT USE ONLY

PROCESSED BY: _____ DATE PROCESSED: _____

INFORMATION SENT: _____