EVMS Eastern Virginia Medical School

SENTARA®

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize and request the following to be sent to the EVMS Department of Otolaryngology – Head and Neck Surgery:

- ☐ Complete medical record – I understand that all information contained in my record including, but not limited to, information relating to psychiatric treatment, drug/alcohol abuse, and HIV/AIDS testing and/or treatment shall be released.

- ☐ Specific medical information that is limited to the following date(s) or date range: _____.

If requesting specific medical records, please check all that apply:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Notes
- ☐ Office Notes
- ☐ Inpatient/Outpatient Notes
- ☐ Laboratory Results
- ☐ Pathology Results
- ☐ Radiology Results
- ☐ Audio/Balance Testing
- ☐ Other _____

I authorize my records to be released to the following:

Sentara EVMS Comprehensive Head and Neck Program
600 Gresham Drive; Suite 1100
Norfolk, VA 23507

Phone: (855) 998-EVMS
Fax: (757) 388-6201

I request the information to be: _____ mailed _____ faxed _____ picked up

This authorization shall remain valid for 90 days unless otherwise specified. I understand that I may cancel this authorization at any time but disclosures made prior to this cancellation would not be affected. I understand that my cancellation is not in effect until delivered in writing to the custodian of my medical record. I understand that if my medical information is disclosed to someone who is not required to comply with federal privacy regulations that such information may be re-disclosed and would no longer be protected. I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment at Eastern Virginia Medical School unless that treatment is tied to a research related treatment.

_____ _____
Patients Full Name Date of Birth

_____ _____
Patient/Guardian Signature Date