COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name:_____ **ID Number:**_____

Person(s)/Organization(s) providing the information:

_____
_____

Person(s)/Organization(s) receiving the information:

_____
_____

Specific description of information (including date(s)):

_____
_____
_____
_____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?_____
   _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No____

DMAS – 219 11/6/06

2. The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials:_____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YR) Initials:_____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but that, if I do, the revocation won't have any affect on any actions the providing organization took before it received the revocation.

Initials:_____

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing)

Printed name of patient's representative:_____

Relationship to the patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

☐ **Refusal to Sign Authorization Form:**

_____

Witness Signature and Date

_____

Print Witness Name

This form is based on current federal and state law and specifically meets the standard of patient privacy under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 45 CFR **§** 164.506.
DMAS – 219 11/6/06