Please fill out and fax this form to :804-765-6101

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

ROI

Patient's Name	Date of Birth	Medical Record Number

Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below: Jeffrey K. Lou MD patient

Facility Authorized to Release my Health Information: Southside Regional Medical Center

Address	City	State	Zip	Telephone Number
200 Medical Park Blvd.	Petersburg	VA	23805	804-765-5000

Agency or Individual(s) Authorized to Receive my Health Information: Virginia Urology (fax 804-521-1061)

Address	City	State	Zip	Telephone Number
9101 Stony Point Drive	Richmond	VA	23235	804-330-9105

Health Information that may be used / disclosed is limited to the following:

☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Progress Notes ☐ Emergency Room Record
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☒ Entire Record ☐ Pathology Report ☐ Fetal Heart Monitor Strips
☐ Other *(specify)* Dr. Jeffrey K. Lou - patient

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐ Treatment/Consultation ☒ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including sensitive information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative	Date/Time

Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if Utilized	Date/Time

Witness Signature	Date/Time	Expiration Date or Event

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Patient Label