INOVA

1ROI

* All items with an asterisk are MANDATORY fields.

* Patient Name _____ Medical Record Number _____

Social Security# _____ * Patient Date of Birth _____

* Contact Phone Number _____ Contact Email _____

* Patient Address _____
Street Address City State Zip Code

*** I authorize Inova Health System to release or disclose the following information to:**

☐ Physician ☒ Other APS Retrieval Services

Phone # (required if records are to be faxed) 800.882.4156

Hoosier Services Inc. Fax # (25 pages or less) 800.882.4957

Name of person or entity to receive information

18032 Lemon Dr.,#C-618 Yorba Linda CA 92886

Street Address City State Zip Code

*** Information to be Released/Disclosed:**

☐ Complete Medical Record
Facility: _____
Dates of admission/treatment requested: _____
☐ Billing Information
☐ Other_____

Abstracts of Medical Record:
☐ Consultations
☐ Discharge Summary
☐ EKG/EEGs
☐ Emergency Room Records
☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Radiology Reports
☐ History & Physical

Other Records:
☐ Physician Orders
☐ Plan of Care
☐ Progress Notes
☐ Psychiatric Admit Note
☐ Psychiatric Evaluation
☐ Radiology Images/CD
☐ Other _____

*** Purpose:**
☐ Medical Follow-Up
☐ Attorney
☐ Personal Use
☐ Disability
☒ Insurance
☐ Other _____

*** Record Disposition:**
☐ Release to MyChart
☐ Please mail the records
☐ Fax to the number above
☐ I will pick up the records
☐ I wish to review the records (You will need to make an appointment for the review)

Fees + Postage (if applicable):

Electronic	Release to MyChart	No charge
	CD or Thumbdrive:	$0.13 per page
	Radiology Images on CD:	$10.00 per CD
	Continuing Care	No charge
Paper	Pages 1-50:	$0.50 per page
	Pages 51+:	$0.25 per page
	Microfilm/Microfiche:	$1.00 per page
	Continuing Care	No charge

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.

_____ _____
* Signature of Patient or Authorized Representative * Date/Time (Authorization will expire six months after date signed)

_____ _____
* Print Name of Patient or Authorized Representative * Relationship to Patient

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Health System

Authorization to Release/Disclose Protected Health Information