UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
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education.virginia.edu/services-outreach/sheila-c-johnson-center

AUTHORIZATION TO RELEASE AND RECEIVE CONFIDENTIAL HEALTHCARE INFORMATION

Client's Full Name _____ Birth Date _____

Street Address _____ Phone (Home or Cell) _____

City, State, Zip Code _____ Phone (Alternate) _____

I understand there may be a fee per page. Fees are waived when copies are sent to other health care providers/agencies/facilities. All other requestors are charged as state and federal laws allow.

I hereby authorize the Sheila C. Johnson Center for Human Services, at the University of Virginia to release and/or receive:

COPIES OF MEDICAL RECORDS (Select all that apply):

- ☐ Audiologic Information
- ☐ Hearing Aid Information
- ☐ Intake Summary
- ☐ McGuffey Reading Center Evaluation Report
- ☐ McGuffey Reading Center Tutoring Notes
- ☐ Observation Notes
- ☐ Psychological/Educational Testing
- ☐ Psychological Treatment Summary
- ☐ Speech-Language Evaluation
- ☐ Speech-Language Progress Notes
- ☐ Speech-Language Treatment Summary
- ☐ School records (Psychological, Educational, Speech-Language, etc)
- ☐ Termination/Discharge Summary
- ☐ Other: _____

Please indicate dates of service as appropriate [from (date) _____]

I understand that if this authorization is for release of medical records, that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions: _____

INFORMATION RELEASE TO/FROM:

NAME (Physician, hospital, agency, organization, individual etc.) _____

Street Address _____

City, State, Zip _____

Phone _____ Fax _____

Purpose of Disclosure ☐ Continued Care ☐ Personal ☐ Legal ☐ Other: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not apply to information that has already been released prior to notification of cancellation. I understand that the information disclosed may be re-disclosed and not be protected by the federal Privacy Rule. I understand that my health care providers may not condition provision of services on whether I sign this authorization.

Signature of Client or Legal Representative _____ **Date** _____

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

Client's Authorized Individual _____ **Date** _____