

**UNIVERSITY OF VIRGINIA HEALTH SERVICES FOUNDATION (HSF)  
AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE BILLING  
INFORMATION**

**DO NOT RELEASE INFORMATION IF THIS AUTHORIZATION IS NOT COMPLETELY  
FILLED OUT – ALL BLANKS MUST BE COMPLETED**

Patient Name \_\_\_\_\_ Medical Record No. \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

1. **I authorize HSF to use or disclose the above named individual's health information as described:**
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
  - Billing and payment information (written itemized statement) from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
  - Billing and payment information (via phone) from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
  - Balance information via phone from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
  - All of the above
3. I understand that I am giving my permission to release copies of information 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:  
\_\_\_\_\_  
\_\_\_\_\_
4. **This information may be disclosed to and used by the following individual or organization:**  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
For the purpose of \_\_\_\_\_  
(If the patient or representative is requesting this release of information, s/he may fill in this blank with "at the request of the individual")
5. I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to P. O. Box 9007, Charlottesville, VA 22906. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire two (2) years from the date signed, unless an expiration date, event or condition is specified as follows:  
\_\_\_\_\_
6. I understand that the information disclosed to the above individual or organization may be redisclosed and not be protected by the federal Privacy rule. If I have questions about disclosure of my health information, I may contact the Supervisor of Patient Accounts.
7. I understand that HSF cannot condition its providing of health care on whether or not I sign this authorization, unless I am requesting care specifically for it to be disclosed under this authorization (for example, a physical for school enrollment.)

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
If Signed by Legal Representative, Describe Authority to Act on Patient's Behalf