

## Authorization for Disclosure of Health Information

I, the undersigned, authorize JORDAN-YOUNG INSTITUTE, 5716 Cleveland Street, Suite 200  
 Virginia Beach, Virginia 23462 to release my health information as noted below:  
 Please return the COMPLETED authorization to this address.

### Patient Information

\*\*\*All sections must be completed in order for request to be processed\*\*\*

Patient Full Name: \_\_\_\_\_ Other Names During Treatment? \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### Release Information To: (THIS SECTION MUST BE COMPLETED)

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Purpose of Request:  Referral by JYI to Another Provider/Phys. Therapy  Second Opinion OR Transfer of Care to Another Physician  
 Personal Records  Other/Reason \_\_\_\_\_

### Information to be Released

Please specify the information to be released:

Office Notes  Labs  Operative Notes  Diagnostic Reports  Physical Therapy Notes

Specify Date(s) of Service: \_\_\_\_\_

Body Part: \_\_\_\_\_

Entire Chart



Initial \_\_\_\_\_

\*\*\* PAYMENT OPTIONS: Check, Credit Card or Money Order  
 Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.

**\*Invoice must be paid before records will be released.**

**All Fees are based on HIPAA guidelines  
 (Code of VA §8.01-413 applies)**  
 ■ Pages 1 – 50 = \$0.50 each Page  
 ■ Pages 51 & above = \$0.25 each Page  
**Plus all postage and handling costs**

Questions about your request or invoice can be answered by calling (757)383-6628 or via email at [medicalrecords@Jordan-younginstitute.com](mailto:medicalrecords@Jordan-younginstitute.com). Please allow 7-10 business days to complete the request.

### Authorization to Release Protected Health Information

**\*Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one

Initial each line below

I DO  DO NOT want information about **\*Mental Health** released \_\_\_\_\_  
 I DO  DO NOT want information about **\*HIV Tests & Related Information** released \_\_\_\_\_  
 I DO  DO NOT want information about **\*Alcohol and/or Substance Abuse** released \_\_\_\_\_  
 I DO  DO NOT want information about \_\_\_\_\_ released \_\_\_\_\_

"Other sensitive information?"



Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete we may be unable to fulfill this request.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for all patients 18 years and older.)

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to disclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by JORDAN-YOUNG INSTITUTE is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.