Patient Name: _____ Medical Record Number _____

Date of Birth: _____ Social Security #: _____ Phone Number: _____

Home Address: _____

1. **Type of Request:** I hereby request that George Washington University Hospital provide me with photocopies of my Health Information, as requested below:

****

2. **Information to be Released:** (include discharge date)s), date(s) of service, etc.)

_____

****

3. **Description of Information to be Released:** (check ALL that apply)

☐ Pathology Reports ☐ Tissue Specimen ☐ Slides ☐ Other

****

4. **Specific Confidential Information Authorized for this Release:**

By signing my **initials** next to the specific category of highly confidential information, I am authorizing George Washington University Hospital to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

_____ HIV/AIDS Related Information
_____ Drug and Alcohol Information
_____ Tuberculosis Information

_____ Sexually Transmitted Disease Information
_____ Genetic Information

****

5. **Release Information To:** ☐ Myself (the patient or representative) ☐ To organization/individual below:

_____ _____ _____

Organization Individual Name Phone

_____

Street Address City State Zip

☐ Fax
☐ Please mail
☐ Please prepare for pickup

6. **Purpose of Release:** I authorize George Washington University Hospital to release my health information for the following specific purpose:

_____

7. **Term/Expiration:** This signed Authorization will expire in **90** days *unless* an earlier date is indicated by you below. Please list a date or event that this Authorization will no longer be valid (*This date may not be more than 90 days in accordance with* George Washington University Hospital's *policy*). This Authorization will no longer be valid after:

_____

8. **Fees:** I understand that George Washington University Hospital is permitted under District of Columbia and federal laws to charge me a fee for photocopies of my medical records and any applicable mailing/postage/shipping fees.

$20.00 for the first 10 pages and
$1.10 per page thereafter

$12.00 per Slide re-cut
Mailing charges per FEDEX, UPS Services

I understand that any information provided to me pursuant to this request will not include information complied in reasonable and anticipation of (or for use in) a civil, criminal, or administrative proceeding or as may otherwise be limited to restricted by applicable law.

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

RI0010

DEPARTMENT OF PATHOLOGY

Authorization for Release of Health Information

75-529 (8/24)

Patient Label

I understand that George Washington University Hospital may deny this request under limited circumstances as provided for under federal and District of Columbia law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed healthcare practitioner selected by the George Washington University Hospital who did not participate in the George Washington University Hospital's decision to deny my request.

I understand that George Washington University Hospital will notify me of its decision to approve or deny my request to obtain a copy of the Requested Information within thirty (30) days of receiving the request if the information is maintained or accessible on-site at George Washington University Hospital or within sixty (60) days if the Requested Information is not maintained or accessible on-site at George Washington University Hospital . If George Washington University Hospital is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

The information to be disclosed from my records is confidential and is protected by federal and District of Columbia law. I understand that once George Washington University Hospital releases my health information to the recipient listed on the Authorization, George Washington University Hospital cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or District of Columbia law governing the use and disclosure of my health information.

I understand that this Authorization will remain in effect until the term of their Authorization expires or I provide a written revocation to George Washington University Hospital's Privacy Officer at the address listed below. The revocation will be effective immediately upon George Washington University Hospital's receipt of my written notice, except that the revocation will not have any effect on my action taken by George Washington University Hospital in reliance on the Authorization before it received my written notice of revocation.

I have read and understand the terms of this Request and I have had the opportunity to ask questions about my rights to access my health information and any Protected Health Information that George Washington University Hospital uses to make medical decisions about me. I also understand that if I have further questions or concerns regarding my Protected Health Information, I may contact George Washington University Hospital's Privacy Officer by mail.

By telephone at: _____ **or by e-mail at:** _____

I hereby authorize George Washington University Hospital to release/disclose the health information and/or materials listed above for the purposes described in this Authorization.

Patient Signature: _____ **Date:** _____

If the patient is a minor or otherwise unable to sign this Authorization then obtain the signature of the authorized representative/individual below.

Description of Authority: _____

Signature: _____ **Date:** _____
(Other than patient)

-NOTICE OF RECIPIENT INFORMATION-

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under part 2 of this form, the following Notice applies to the information you have received pursuant to this authorization.

This information has been disclosed to you from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

RI0010

DEPARTMENT OF PATHOLOGY

Authorization for Release of Health Information

75-529 (8/24)

Patient Label