VIRGINIA
EAR NOSE & THROAT
*The Choice is Clear*

**Address:** 3450 Mayland Court, Henrico, VA 23230
**Phone:** 804-484-3700 Ext 2012
**Fax:** 804-282-5431

VIRGINIA ENT
*Surgery Center*

**Address:** 6600 West Broad Street, Richmond, VA 23230
**Phone:** 804-401-8383
**Fax:** 804-303-7955

## Instructions for Completing the Authorization for Release of Health Information

Following is our Authorization for Release of Health Information. This form may be used to request release of your health information:

- To you,
- To someone other than you (e.g., another doctor), or
- **FROM** another provider to be sent to Virginia ENT

This form may only be used to make one request. If you have more than one request (e.g., you want records for yourself AND you want them sent to another provider) you will need to complete two separate forms.

**Submission:** Upon completion, the form may be submitted in the following ways:

- By facsimile to 804-282-5431
- In person at Virginia Ear, Nose & Throat, 3450 Mayland Court, Richmond, VA 23233

**If you have any questions about completing the form, please contact our Medical Record staff at 804-484-3700 Ext. 2012.**

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# CHARGE FOR COPIES OF MEDICAL RECORDS

Patients may be charged a reasonable fee for medical record related services such as obtaining information from their medical records and for the completion of forms. Please note that all fees are payable prior to the service being provided. Below are Virginia ENT/Virginia ENT Surgery Center's charges for these services:

- **Copies from paper or electric and/or digital format:**
  - **$0.50 per page** for first 50 pages
  - **$0.25 per page** for additional pages

- **Disability forms, FMLA forms, or other forms:**
  - **$30.00 per form**. Payable prior to completion of forms by physician.

- **Completion of letters related to disability or flexible benefits plans:**
  - **$35.00 per letter/form.** Payable prior to letter or form being completed by physician.

- **Workers' Compensation:**
  - There is **NO** charge for forms completed or medical records in connection with Workers Compensation.

- **Handling Fees:**
  - There is a **$20.00 handling fee**, in addition to the above fees, for records sent to insurance companies or to an attorney's office.

*There is no charge to send medical records directly to another physician.*

**Please contact our office at 804-484-3700 Ext. 2012 if you have additional questions.**

Thank you,

Virginia Ear, Nose & Throat Associates,

VIRGINIA
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VIRGINIA ENT
*Surgery Center*

**Attn: MEDICAL RECORDS Address:** 3450 Mayland Court, Henrico, VA 23230 **Fax:** 804-282-5431

## Authorization for Release of Health Information

**This form must be filled out in its entirety to ensure proper processing.**

**Patient Name:** _____ **Patient #:** _____

**Date of Birth:** _____ **Physician's Name:** _____

I hereby request that Virginia Ear, Nose & Throat Associates (**check one only**):

☐ Provide a copy of my health information **for me** (please check which option) ☐ paper ☐ fax ☐ email ☐ CD
_____ Please initial here to accept any security risk for emailed records.

***Patient address/email:*** _____

☐ Release my health information **to** (specify below) (please check which option) ☐ paper ☐ fax ☐ CD

☐ Request copies of my health information **from** (specify below)

_____ _____
(Name of person or entity) (Fax number)

_____
(Street address) (City) (State) (Zip Code)

Please include information for the following dates of service _____
*(If left Blank, Information for all dates of service will be included & sent.)*

_____ Please initial here if you would like to **exclude** records from other healthcare providers

The purpose for this request is:

☐ At my request ☐ For my healthcare/treatment ☐ For legal purposes ☐ For payment/insurance purposes

This authorization is valid for one year or until _____, unless I notify Virginia ENT in writing that it is rescinded sooner.
(Insert date)

I understand that I have the right to access my health information in accordance with Federal and State regulations and the policies of Virginia ENT. I also understand that Virginia ENT may charge me for copies, and I have been informed of the fee schedule.

I understand that Virginia ENT has the right to deny me access to my health information in certain circumstances in accordance with Federal and/or State regulations. If access is denied I understand that the reason for the denial will be given to me in writing and it will describe whether I have the right to have the denial reviewed by a Licensed Healthcare Professional.

_____ _____
Patient or Legal Representative Date

_____
Relationship of Legal Representative to Patient

Rev. 07/2023