myPRIVIA™
YOUR HEALTH YOUR WAY

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name	Patient's Date of Birth
Address Patient's	Telephone Number
City, State Zip Code	Any Other Names Used

I hereby request that Privia Medical Group use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all):

   _____

2. Be sent to the following person / entity at the address listed:

   _____
   Name

   _____
   Address

   _____
   City, State Zip Code

3. I authorize disclosure of the following specific information (include dates of service):

_____

_____

_____

NOTE: UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
☐ YES, PLEASE DISCLOSE THIS INFORMATION: _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless otherwise specified below, I understand that my PHI will be provided in paper format**. I hereby request that my PHI be provided in the following format:
☐ On an encrypted USB drive ☐ On an unencrypted USB drive ☐ Other (please specify) _____

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.

6. I understand I may revoke this authorization by notifying Privia Medical Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

7. My purpose/use of the information is for ☐ personal use; ☐ or other (please specify) _____.

8. This authorization expires on _____ _____, 20_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	Date of Patient's Signature	Patient's Date of Birth
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	Date of Legal Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

For Privia Use Only

Date Received	Date Processed	Format	Fee	Pt Notified of Fee	Medical Record #