AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Print Clearly:

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Last Date of Service: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law and state law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies, which you may have upon request.

To better allow us to process your request, please indicate the type of request you are making on this form: (check all that apply)

_____ Access to simply review my health information

_____ Access to obtain copies of my health information.

Signature _____ Request Date _____

** Please note there is a required minimum fee of $14.00 to obtain copies of your health information. Please contact RAA in order to determine the total required fee in order to have your request processed.

This form along with the required payment must be returned to RAA in order to receive your records.

Payment can be made via check, credit card or cash through the mail, over the phone, or on our website at www.raaems.org

The authorization form can be returned via mail or fax.

2400 Hermitage Rd

Richmond, VA 23220

Fax: 804-254-1149

Phone: 804-254-1150