INOVA™
Join the future of health.

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT LAST NAME: ____________________________________FIRST NAME: _______________________MI: _______

ADDRESS: ____ APT #: __________

CITY: ____STATE: _____________ ZIP: __________________

Phone: HOME: (______) ________________ WORK: (______) _________________CELL: (______) __________________

SSN #: ________- ________- _________ SEX: MALE / FEMALE DATE OF BIRTH: ______/ ______/______ AGE: _____

Next of Kin/Emergency Contact: ____
Name Relationship Phone Number

EMPLOYER: ______________________________ EMAIL ADDRESS: ____

Acknowledgement of Receipt of Notice of Privacy Practices: I certify that I have been made aware of Inova health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills, or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health Systems' duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request a copy be mailed to me by calling 703-204-3342.
Inova Health System reserves the right to change the privacy practices that are describes in the **Notice of Privacy Practices**. I may obtain a revised or most recent version by mail by calling the above number, in person at my next appointment, or online at www.inova.org.

PREFERRED PHARMACY: Name:____

Address:____ PH: ____________________

PREFERRED LABORATORY: Name:____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (Optional)

I authorize **Inova VIP 360°** to release the following information to: ____
Name of Person(s), Physician or Physician Group

____
Street Address City State Zip Code Phone

Information to be released/ Disclosed:

ALL MEDICAL RESULTS ASSOCIATED WITH THIS VISIT (**or** choose from the following)

- Health history form / Physical Exam
- Audiometry results
- Lab
- Pulmonary function studies
- Vision Testing
- Genetic / Genomic Test Results
- Vaccinations
- EKG / Stress test
- X-ray films / x-ray report
- Colonoscopy report
- Mammography report
- Other: _________________________________

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations. I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
I understand that I am under no obligation to sign this form. Inova VIP 360° may, however, condition the provision of health care that is solely for the purpose of creating protected health information for the above named recipient(s) on my signature of this authorization, in accordance with the Health Insurance Portability and Accountability act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, 164.508 (b)(4).
I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2)

____ ________________________________
SIGNATURE OF PATIENT or REPRESENTATIVE *(Required)* DATE