



## HOW TO REQUEST A COPY OF YOUR MEDICAL RECORDS OR IMAGES OF RADIOLOGICAL EXAMS

To request a copy of your medical records from Rockingham Memorial Hospital, including RMH physician practices, you will need to complete an authorization form at the back of this packet.

Please read the entire authorization before completing the form with the following information:

- Print patient's name, date of birth, social security number and phone number
- Name, address, and telephone number of person or organization to receive the records
- Purpose for the information requested
- If any sensitive information is to be included, check the boxes that apply
- Check the boxes of the records or reports and date(s) you are requesting
- Your signature or a legal representative's signature
- If signed by a legal representative, note relationship to patient
- Print name of patient representative, if applicable
- Date signed

The authorization is valid for 1 year from the date of signature unless noted differently on the authorization form.

RMH charges for copies of medical records as follows:

- Patients: pages 1-20 are free of charge; pages 21+ are \$.30 per page
- All other requestors are charged as state and federal law allows

Deliver the completed authorization form by mail or in person to:

RMH  
Release of Information, HIM Dept.  
2010 Health Campus Drive  
Harrisonburg, VA 22801

Or RMH  
Release of Information, HIM Dept.  
3320 Emmaus Road  
Harrisonburg, VA 22801

Or fax to:

RMH, Release of Information  
540-564-7274

Please contact Release of Information, Health Information Management (HIM) Department at 540-564-7275 with any questions

Release of Information hours of operation: Monday – Friday, 8:00 am – 4:30 pm

When picking up the copies of medical records please make sure to have:

- Photo ID
- If someone else is picking up the films/CD other than you, please make sure to write them a note with permission. The note needs to state their name and must be signed by you. The person picking up the film must also provide a photo ID.

**Please note:**

Processing of medical record copy requests is completed at the main Release of Information office in the HIM Department located at 3320 Emmaus Road, Harrisonburg, VA. A Release of Information Specialist is also located in the main lobby of the hospital, 2010 Health Campus Drive Harrisonburg, to assist patients Monday – Friday, 8:00 am – 4:30 pm.

**Imaging Department Film/CD/Electronic Transfer**

To request images of radiological exams please call 540-689-1500.

Please have the following information to provide to staff when you call:

- The name of the doctor or location the films/CD are to be taken to
- Date the films need to be ready
- What Imaging study is needed

When picking up the films/CD please make sure to have:

- Photo ID
- If someone else is picking up the films/CD other than you, please make sure to write them a note with permission. The note needs to state their name and must be signed by you. The person picking up the film must also provide a photo ID.

**Please note:**

We offer electronic image transfer to University of Virginia and Augusta Healthcare.

How to get to Imaging Services:

- Park in parking lot A.
- Come in the main entrance and take a left.
- Pass the Coffee Cup and Imaging is the next section to the right.

Imaging Film Pick up hours of operation: Monday- Friday 6:00 a.m. - 8:00 p.m.,  
Saturday & Sunday 8:00 a.m. - 6:00 p.m.

Revised 11/10/11



### AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Phone: \_\_\_\_\_

**I authorize Rockingham Memorial Hospital to use or disclose my health information as described below:**

- Release information to: \_\_\_\_\_
- Receive information from: \_\_\_\_\_  
Name of person or organization receiving information
- Exchange health information on an ongoing basis with: \_\_\_\_\_  
Phone and Fax or Address of person or organization receiving information
- May take Pictures of \_\_\_\_\_

**Purpose of disclosure:**

- Patient request
- Healthcare
- Birth verification
- Other: \_\_\_\_\_

**Sensitive Information:** (Patient must specifically check to include the following information)

- Psychiatric care of psychological assessment
- Psychotherapy Notes
- Alcohol and/or drug abuse related information
- HIV testing, and/or AIDS information

**The specific records/reports to be disclosed include:**

- Discharge Summary - Date(s) \_\_\_\_\_
- X-ray, Imaging Report - Date(s) \_\_\_\_\_
- History and Physical - Date(s) \_\_\_\_\_
- Lab - Date(s) \_\_\_\_\_
- Emergency Dept. Record - Date(s) \_\_\_\_\_
- Operative Report - Date(s) \_\_\_\_\_
- Consultation - Date(s) \_\_\_\_\_
- Pathology Report - Date(s) \_\_\_\_\_
- RMH Physician office notes - Date(s) \_\_\_\_\_
- Billing Record - Date(s) \_\_\_\_\_
- Complete Record - Date(s) \_\_\_\_\_
- Other, please specify - Date(s) \_\_\_\_\_

I understand that this authorization is voluntary. If I do not sign this form, my healthcare from RMH and the payment for this healthcare will not be affected, unless I am receiving treatment only for the purpose of providing medical information to a third party, such as my employer. I understand that I can cancel this authorization by written request to Release of Information, Health Information Management Department, but it will not affect information that was released prior to notice of cancellation. I understand that this authorization will expire in 1 year from the date of my signature below; or until \_\_\_\_\_ (not to exceed 1 year). I understand that once my information is released, it may no longer be protected by federal privacy regulations. Alcohol, drug, HIV, ARC and/or AIDS information, if present, will be disclosed as I have requested above. I understand this information is protected by federal and state privacy laws and may not be disclosed without authorization, unless required or permitted by law.

I understand that I will be charged for copies of medical records.

\_\_\_\_\_  
Patient/ Legal Representative Signature

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

Reason if not signed by patient:  Minor  Death  Incompetence  Other: \_\_\_\_\_

For office use only: M# \_\_\_\_\_ V# \_\_\_\_\_

**REMINDER: Refer to RMH Release of Information Policy before releasing information on a minor 14-17 years old**