SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE

Health Information Management Department
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AUTHORIZATION FOR RELEASE OF INFORMATION ON DECEASED PATIENTS

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS

Patient Name: _____
Last First Middle

Patient's Date of Birth, if known: _____

Patient's SSN, if known: _____

As the person signing this form, I do hereby certify that the above named patient is now deceased and that I am the closest living relative of the deceased as shown in the priority list of the Code of Virginia*. I authorize Southwestern Virginia Mental Health Institute to release medical and psychiatric information from the records of the above named patient, including substance abuse and HIV (AIDS) information, if applicable.

Reason for request of records: _____

PLEASE RELEASE REQUESTED RECORDS TO:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone number: _____ Fax number: _____

I understand these records are protected under Federal and State laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. This consent will expire when action has been taken on it. A photocopy of this consent shall be considered as valid as the original.

Signature: _____ **Date:** _____

Relationship to Patient: _____

Witness: _____ **Date:** _____

*Per § 32.1-127.1:03 Health records privacy, Code of Virginia: If the health records are those of a deceased individual, records may be released to the personal representative or executor of the deceased individual or if there is no personal representative or executor, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship.