HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

v1.3

Patient's Full Name | Patient's Date of Birth

Address | Patient's Telephone Number

City | State | Zip Code | Any Other Names Used

I request that my provider share 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 locations):

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

   Name

   Address | Telephone Number

   City | State | Zip Code | Fax or Email Address for Delivery

3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization records Only ☐ Service dates only: _____ to _____ ☐ Specific information only:

NOTES

1. Information about alcohol/substance use, HIV/AIDS and Mental Heath issues is includes unless you specifically request that it be excluded in the space below. Psychotherapy notes, however, are never included.
2. If you request we send only a portion of your records to a treating provider, we will send your records to you to give to your provider; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER. ☐ PLEASE EXCLUDE THE FOLLOWING INFORMATION**:

Signature:_____

3. 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. If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format: ☐ via secure electronic delivery; **or** ☐ other (please specify below)

4. If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
6. 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 will then no longer be protected by federal privacy regulations.
7. I understand I may revoke this authorization by notifying my provider **OR** in info@vbdiagnostics.com 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.
8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____
10. This authorization expires on _____ _____, 20____, **OR** upon occurence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.

NOTE: 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 cpoing the PHI, costs for supplies, labor for creating a summary/explaination of the PHI if a summary or explaination was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you **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 is 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