HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

All sections are required to be filled out in order for the request to be processed.

Patient Information:
Name: _____
Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Cell Phone-Required:_____

Reason for Request:
☐ Personal Copy
☐ Continuity of Care
☐ Legal/Insuranc
☐ Other_____

Records to be Provided from: ***(Enter Your Doctors/Office information)***
Facility/Provider:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____
Fax:_____

Send Records To:
Person/Facility/Agency:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____
Fax-Required:_____
Email:_____

Information to be Disclosed: **Dates of Service requested: _____ To _____**

☐ Complete Record ☐ Abstract/ Summary ☐ ER Records ☐ Immunization Record ☐ Itemized Billing Records

☐ Office Notes ☐ Laboratory Report(s) ☐ Prenatal Records ☐ Physical Therapy ☐ Images CD (Xray, MRI, CT) ☐ Imaging/Radiology Reports

☐ Test Result (s) of: _____

☐ Other: _____

I understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/or drug abuse. I authorize the release of all such items EXCEPT for those which I have marked below. By checking the boxes next to these items I understand that the following information will NOT be released.

☐ Alcohol or Substance Abuse Records ☐ HIV and/or STD Testing and Results ☐ Mental Health Records ☐ Genetic Records

By signing this authorization form, I understand that:

•Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. By submitting this request I am accepting all associated fees and authorizing the provider/VRC to process my request for records.

•I understand that communication via email over the Internet are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. The provider/VRC has notified me of the risks and will not be held liable if I choose to have my records sent by email.
•I have the right to revoke this authorization on at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the facility at which this request is received. Revocation will not apply to information that has already been disclosed in response to this authorization.
•I have a right to inspect and copy the health information disclosed as a result of the delivery of this authorization
•Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
•Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
•Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules.
•If any, Consequences of Failure to consent:_____

_____ _____ _____
Patient or Authorized Representative Signature | Date | Relationship to Patient (if applicable)

_____ _____
Witness Signature required to release Mental Health Records | Date

Failure to complete all fields on this form may invalidate this request