Virtua Medical Group

Authorization to Release Health Information

(Please complete all sections)

1. Patient Information

Patient's Full Name _____ Date of Birth _____

Patient's Address _____ Patient's Home Phone Number _____

City, State _____ Zip Code _____ Patient's Work Phone Number _____

2. Health Information Release Instructions

Information to be released **FROM**:

Practice / Physician's Name _____

Address _____

City, State _____ Zip _____ Telephone _____

Information to be sent **TO**:

Name (Patient / Practice / Company) _____

Address _____

City, State _____ Zip _____ Telephone _____

3. Authorization

I,_____, do hereby authorize_____to release my "Health Information", as defined below: (check one)

1) _____Routine: 2 years of progress notes, 1 year of other records including testing results

2) _____Only Medical Records pertaining to _____
List conditions, treatments or type of medical records

3) _____All Medical Records, Or All Medical Records from_____ through _____
Date Date

4) _____All Medical Records **EXCEPT**_____
List Exceptions

NOTICE: Unless excluded above, this Authorization is for FULL DISCLOSURE of ALL RECORDS. I acknowledge that such information may include the testing, diagnosis and /or treatment of HIV, AIDS, sexually transmitted diseases, mental health/psychiatric care, genetic information and/or substance abuse.

4. Purpose of Information Release

Insurance Change | Moving; transferring | Other_____
Disability Determination | Workers Compensation | Personal Injury

5. Health Information

This Authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this Authorization will expire ninety (90) days from the date signed below. This Authorization is fully understood and is made voluntarily on my part. I acknowledge that once my health information has been released, it may be subject to re-release by the recipient and no longer protected. Virtua may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed

SIGNATURE: ☐**Patient** ☐ **Parent** ☐ **Other** _____ **Date** _____ **Witness** _____ **Date** _____

If **OTHER** is checked above, state relationship:_____

Copy Charge Notification*:* There may be a charge for copying medical records as most offices utilize an outside copy service. Please contact the office you are requesting records from for details.

Medium Source: ☐Paper ☐Electronic (if left blank, paper copies will be released)

☐**I am also requesting records from another VMG Practice** _____