AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. Patient Information

____ _______________________

Patient's Full Name *Date of Birth*

____ _______________________

Patient's Address (Number, Street, City, State, Zip Code) *Patient's Home Phone Number*

2. Information to be Released From:
Indicate the name of the Virtua Medical Group (VMG) practice location where you are requesting medical records from. Submit your completed Authorization in person or by mail to the practice location listed below.

____

VMG Practice / Physician's Name

____

Address (Number, Street, City, State, Zip Code)

❑ I am also requesting records from an additional VMG Practice (list name of practice): ____________________

3. Information to be Provided To:
Indicate the name of the person or institution where you would like the requested medical records sent.

____

Name of Person or Institution

____ _______________________

Address (Number, Street, City, State, Zip Code) *Phone Number*

4. Description of Health Information to be Disclosed: (check one box below)

❑ Routine: 2 years of progress notes, 1 year of other records including testing results
❑ Only Medical Records pertaining to ____
List conditions, treatments or type of medical records

❑ All Medical Records, Or All Medical Records from________________ through ____________
Date *Date*

❑ All Medical Records **EXCEPT:** ____.
List Exceptions

5. Purpose of the Requested Disclosure:
❑ At my request/personal ❑ Continuity of Care ❑ Legal ❑ Insurance ❑ Other (*explain*):______________________
❑ Disability Determination ❑ Moving; Transferring ❑ Workers Compensation

6. Format of Records: ❑ Paper ❑ Electronic (HealthMark Corp will send instructions)

7. Authorization
I hereby authorize VMG to disclose the health information as described above. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and birth control and abortion (family planning). I specifically authorize the disclosure of such sensitive health information to the person or institution noted above.

I understand that my authorization will automatically expire ninety (90) days from the date of signature on this form. I understand that I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and submit my written revocation to the VMG practice location who obtained this request I understand that the revocation will not apply to health information that has already been disclosed in response to this authorization. I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and/or state law.

Signing this authorization is voluntary and I understand that VMG may not condition treatment, payment, enrollment or eligibility for benefits on my signing or refusal to sign this authorization. By signing below, I understand that I am authorizing VMG to disclose the health information as describe above.

8. Signature:

_______________________________ ______________ ______________________ __________

❑ **Patient** ❑ **Parent** ❑ **Other** **Date** **Witness Name** **Date**

If **Other** is checked above, indicate relationship to patient (i.e. spouse, parent, legal guardian, etc.):____________________