



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 person or institution where you are requesting medical records from. Submit your completed Authorization in person or by mail to the practice location listed below.

Name of Person or Institution

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.): _____