AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO VIRTUA MEDICAL GROUP (VMG)

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. PHI to be Released From:

Indicate the name of the facility or institution where you are requesting PHI from. Submit your completed Authorization in person or by mail to the location listed below.

_____ _____
Name of Facility or Institution *Fax Number*

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

3. PHI to be Provided To:

Indicate the name of the VMG practice where you would like the requested PHI to be sent.

_____ _____
Name of VMG Practice or Physician *Fax Number*

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

4. Description of PHI 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 of PHI:

❑ At my request/personal ❑ Continuity of Care ❑ Legal ❑ Insurance ❑ Other (*explain*):_____
❑ Disability Determination ❑ Moving; Transferring ❑ Workers Compensation

6. Format of Records:

❑ Paper ❑ Electronic

7. Copy Charge Notification:

There may be a charge for copying medical records. Please contact the location where you are requesting records from for details.

8. Authorization:

I hereby authorize _____ 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

reproductive health care services, including, but not limited to, pregnancy, contraception, and termination or loss of pregnancy. I specifically authorize the disclosure of such sensitive health information to the person or institution noted above., including information protected by 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records), understanding that substance use disorder records are subject to special federal confidentiality protections.

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 location where I submitted this authorization. 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. However, I understand that records concerning substance use disorder treatment that are protected by 42 CFR Part 2 may not be redisclosed by the recipient without my specific written consent or as otherwise permitted by 42 CFR Part 2, and that a general authorization for release of medical information is NOT sufficient to permit redisclosure of substance use disorder information.

Signing this authorization is voluntary and I understand that _____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 _____to disclose the health information as describe above.

9. Signature

Signature of Patient or Patient's Legal Representative (as applicable)	Date	Witness Name

Name of Patient's Legal Representative (Print)	Relationship to Patient or Statement of Authority to act on Patient's Behalf (i.e. spouse, parent, legal guardian, person acting *in loco parentis*, etc.)

Note to Recipient: To the extent that the records disclosed to you pursuant to this Authorization contain information protected by 42 CFR Part 2 (the federal regulations governing Confidentiality of Substance Use Disorder Patient Records), you are hereby notified that 42 CFR Part 2 prohibits you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31)