



AUTHORIZATION FOR
 DISCLOSURE OF PROTECTED HEALTH
 INFORMATION (PHI)
 (Patient's Permission to Release
 Information in the Medical Record)

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

Purpose Continuity of Care Insurance Legal Workers compensation
 Personal/Other (specify) _____

Where do you want the information sent? (Fill in boxes below):

_____ should provide my records to: Self Person(s) who may receive my information (indicated below):

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail (if applicable):

What records do you want? (Fill in the dates and check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

- Complete Medical Record, with images (x-rays, photos)
- Complete Medical Record, no images

OR

The items checked below (check all that apply):



- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Photos, Videos, Digital or Other pictures |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Private Information about AIDS or HIV | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Mental Health Care or Services | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Billing Records |

Other (please specify):

Note: If you selected psychotherapy notes for release, this authorization cannot release any other type of protected health information.

How would you like your records delivered?

- Paper
- Home Delivery
- In-Person Pickup
- Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Expiration

This authorization will expire on the following date or event: _____.

How to Revoke This Authorization

I understand that I may revoke this Authorization, in writing, by sending my request to revoke my authorization to

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Authorization as a Condition to Treatment

I understand that I do not have to sign this authorization to be treated at Vibra, unless:

- I am treated at Vibra only to give health information to a third party (such as for an employee physical exam), or



- I need treatment related to a research study. In this case, Vibra will not treat me unless I sign this Authorization.

My Rights

I have a right to inspect or obtain a copy of the health information that I am authorizing the use or disclosure of.

I have a right to receive a copy of this authorization.

Potential Redisclosure

I understand that persons who receive health information about me from Vibra could redisclose my information to others, unless Federal laws say they cannot. I give Vibra permission to copy this Authorization and give it to persons who receive my health information from Vibra.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person with permission to act on the Patient's behalf. I will not hold Vibra, its officers, trustees, employees, agents, or contractors responsible for anything that may happen from the use or release of my PHI.

Vibra recognizes a patient's right under HIPAA to access copies of their health information. There may be charges associated with processing a request and producing requested records.

Please print your name and sign below:

Print Patient Name

Patient's Signature

Date

Print Patient's Authorized Representative Name

Signature of Patient's Authorized Representative

Date



Relationship of the Representative to the Patient