



**PATIENT INFORMATION**

**Patient Full Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Phone Number** \_\_\_\_\_

**PARTY AUTHORIZED TO RELEASE RECORDS**

**Provider or Facility Name :** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**I authorize the above entity to release the following; (Circle all that apply)**

- |                        |                        |                  |                   |
|------------------------|------------------------|------------------|-------------------|
| All records, All Dates | Initial Consult Report | Operative Report | Discharge Summary |
| Radiology Reports      | Lab Reports            | Psychiatric Eval |                   |

**Other:** \_\_\_\_\_

**PARTY AUTHORIZED TO RECEIVE RECORDS**

**Receiving Party** \_\_\_\_\_ **Fax#** \_\_\_\_\_

**AUTHORIZATION & CONSENT**

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans, or health care clearinghouses, which must follow federal standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights with Respect to this Authorization:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above-named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for the duration that I am an active patient. To initiate revocation of this authorization, I must submit this in writing to VPRC. 3) I understand that a digital replication of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by federal law. 5) I understand that I have the right to refuse to sign this authorization, I am signing this authorization voluntarily, and that treatment, payment, or eligibility for benefits may not be conditioned on obtaining this authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of; Alcohol, Drug Abuse and/Psychiatric records, Sexually Transmitted Disease(s), and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to obtain copies of my health information, by contacting the Compliance/Privacy Officer.

Expiration Date: This authorization is valid while under active treatment, and will expire upon discharge from the practice or on the following date \_\_\_\_\_. If left blank, authorization will be valid for one year.

I have reviewed and understand the content of this authorization form. By signing this authorization, I am confirming it accurately reflects my permission.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_