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Authorization to Use or Disclose Protected Health Information

I hereby authorize _____ to use or disclose the following information from the health records of the individual whose name is described below:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Social Security #: _____

I authorize the above-named facility to release medical, mental, alcohol and/or drug abuse, HIV testing, AIDS, eating disorders or other medical information of a sensitive nature to the following individual(s) or organizations(s):

VMedcare Fax 813 822-0023

This information for which I am authorizing disclosure will be used for the following purpose: Ongoing Medical Care
Dates of Service to be released: Last 3 yrs, but please release all colonoscopy and Cardio Tests

The type of information to be used or disclosed is as follows:

□ Abstract/Chart Summary	☐ Operative / Procedure Reports	□ Immunizations	□ Lab/ X-ray / Imaging Results
□ Discharge Summaries	☐ (Colonoscopy) (All)	□ EKG/Echo/Heart Cath (ALL)	□ ER Records
□ History/Physical Reports	☐ Consult Reports	□ Progress Notes	□ Other: _____

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

Signed: _____ Date: _____

☐ Patient or authorized person	☐ Parent	☐ Legal Guardian	☐ Power of Attorney	☐ Executor	☐ Photo ID Checked

Witness: _____ Date: _____

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