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.

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.

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: The records which have been disclosed to you pursuant to this Authorization may be protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.