



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 Fax:
Recipient Mailing Address:	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