VIBRA HOSPITAL OF SPRINGFIELD™

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 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):

- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Consultation Reports
- ☐ Private Information about AIDS or HIV
- ☐ Mental Health Care or Services
- ☐ Psychotherapy Notes
- ☐ Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse
- ☐ Photos, Videos, Digital or Other pictures
- ☐ Progress Notes
- ☐ Lab Tests
- ☐ X-ray Reports
- ☐ 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

VIBRA HOSPITAL
OF SPRINGFIELD
TM

_____

Relationship of the Representative to the Patient