Form #114

Revised: 3-27-2020

RELEASE OF INFORMATION AUTHORIZATION

PRINT PATIENT NAME:

Last First MI

ID/#:

DOB: ☐ MALE ☐ FEMALE

Facility/ Entity Disclosing the Information Date

Facility/ Entity Receiving the Information Date

Address:

Fax #:

Phone #:

I hereby give consent to disclose the following information from my medical record to the facility/entity listed above.

☐ Records related to treatment of

Dates From To

☐ Physician/Provider's summary of my diagnosis, medication, treatments, prognosis and recent care.

☐ Admission Reports ☐ Discharge Summary/Reports ☐ X-Ray Reports

☐ Mental Health Reports ☐ Psychiatric Summary Reports ☐ Laboratory Reports

☐ Summary Reports ☐ Special Studies ☐ Immunization History

☐ Other:

Per the HIPAA Privacy Rule §164.508{c}, I understand that once disclosures of the above records have been made, the information may be re-disclosed by the recipient and are no longer protected by federal privacy regulations.

☐ Substance Abuse Treatment History and Counseling Records - Dates From To

Per 42CFR Part 2 regulations, I understand that my substance abuse treatment history and counseling records may only be disclosed to the above noted facility and ***that any re-disclosure by them is strictly forbidden without my specific consent.***

Purpose of Disclosure: ☐ Continuity of care ☐ At my request ☐ Other:

I understand that I may revoke this authorization in writing at any time except for any previous disclosures made based upon it.

This authorization expires on this date: OR, upon this event or condition:

*If no date or other event is specified, this authorization will expire after one year from today's date.

I sign this willingly, and I release VitalCore Health Strategies, {provider} , and the facility from any liability which may result from this disclosure of information.

SIGNATURES

Individual/Guardian Signature **Date**

Witness Signature **Date**