Vida Care
Medical Center

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

This form complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its privacy rules. It outlines the purpose of this form and how your health information may be used.

PRINCIPAL PURPOSE(S): This form allows Vida Care to request, use or share your protected health information (PHI).

ROUTINE USE(S): With your authorization, Vida Care may disclousure your health information with you, or third parties **within 3 to 5 business days.** This can be for personal reasons, insurances, ongoing medical care, school, legal matters, or other purposes you specify below.

DISCLOSURE: It's voluntary. If the authorization form is not signed, your medical records will not be released.

Client Name: _____ **DOB:** _____

☐ I am the client and authorize the use or disclosure of my health information.

☐ I am the client's representative and have the authority to act on my client's behalf.

By signing this form, I authorize the release of health information, including protected health information. I authorize Vida Care to:

disclose to		**obtain from**	
Please enter Provider name & contact information	_____	*Please enter Provider name & contact information*	_____
	_____		_____
	_____		_____

INFORMATION MAY BE DISCLOSED BY: Vida Care and any health plan, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider that has provided payment, treatment or services to me or on my behalf.

INFORMATION TO BE DISCLOSED:

_____General Medical Records, including TB _____Progress Notes _____Consultations _____History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Diagnostic Test Reports

Specify Type of test(s): _____

_____ Other: _____ Specify dates of service: _____

PURPOSE OF DISCLOSURE:

☐ Treatment ☐ Personal Use ☐ Billing/Payment ☐ Continuity of Care ☐ Other (specify)

EXPIRATION DATE: This authorization will expire (date) _____ . If an expiration date is not specified, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary and that treatment, payment, enrollment, or eligibility for benefits cannot be coditioned on whether I sign this authorization.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. 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, Medicaid and Medicare.

FEES FOR COPIES: I understand that federal and state laws permit certain fees to be charged for the copying of patient records and that I may be charged in accordance with such laws.

I request and authorize the disclosure of information described above.

Patient/Guardian/Caregiver Signature: _____ **Date:** _____

Printed Name Patient/Guardian/Caregiver: _____ **Relationship to Client:** _____

Witness (optional): _____ **Date:** _____