Vibrance Internal Medicine

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize (name and phone number of provider)

_____

_____

_____to disclose the following information from records of:

Patient Name:_____
Date of Birth:_____
Address:_____

To:_____

Covering the period(s) of healthcare:
From:_____ To:_____

Information to be disclosed:
Office Notes:_____ Lab Reports:_____ X-Rays Reports:_____
Consultation Reports:_____ Other:_____

Is this Permanent Transfer of your records? - Please Circle - **YES NO**

Signed:_____ Date:_____
Patient

_____ Date:_____
Legal Representation of Patient

_____ Date:_____
Witness

I hereby revoke authorization.
Signed:_____ Date:_____
Unless otherwise revoked, this authorization will expire 90 days from the date of signature.

Treatment and/or payments are not conditioned on signing this authorization. Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient, and no longer protected by HIPAA Privacy Rule 164.508. Vibrance Internal Medicine, its employees, officers, and Physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent and authorized herein.
I understand this authorization may be revoked, in writing, at any time, except to the extent that action has been taken in reliance on this authorization. Written notice may be to a Medical Record clerk within Vibrance Internal Medicine or disagree.