HIPAA Authorization

Authorization for Use and Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Full Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Email:** _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Vitality Health At Your Door** to use and/or disclose my protected health information (PHI) as described below. I understand this authorization is voluntary and that I may refuse to sign it.

Information to be disclosed (check all that apply):

■ Complete medical records

■ Office/visit notes

■ Laboratory results

■ Diagnostic imaging reports

■ Medication list

■ Wound care documentation / photographs

■ Discharge summary

■ Other: _____

Disclose TO (recipient):

Name / Organization: _____

Address / Fax / Email: _____

Disclose FROM:

Name / Organization: _____

Address / Fax / Email: _____

Purpose of disclosure:

■ Continuity of care / treatment

■ Insurance / billing

■ Patient request

■ Legal

■ Other: _____

EXPIRATION & REVOCATION

This authorization expires on (date): _____ or one (1) year from the date of signature, whichever comes first.

I understand that I may revoke this authorization at any time by submitting a written request to Vitality Health At Your Door. Revocation will not apply to information already disclosed in reliance on this authorization.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____