VIDA FAMILY PRACTICE PC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes **VIDA Family Practice, PC.,** to use or disclose copies of certain medical record information as specified below:

PATIENT NAME _____ BIRTH DATE:_____

MED REC#_____ ID#:_____PHONE:_____

ADDRESS: _____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE: ☐ **ENTIRE MEDICAL RECORD**

☐ History AND Physical ☐ Discharge Summary ☐ Operative Reports ☐ LAB Reports
☐ Pathalogy Reports ☐ Progress Notes ☐ Orders ☐ X-RAY Resluts

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.

This Authorization will remain in effect:

☐ From the date of this Authorization until:_____
☐ Until the following event occurs:_____

Unless otherwise noted above this authorization will remain in effect 180 days from this date

THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

NOTICE TO RECIPIENT OF COPIES OF ALCOHOL AND DRUG ABUSE MEDICAL RECORDS:

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Chap. 1, Part 2, Subpart Cə § 2.32). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 for the first offense and $5,000 in the case of a subsequent offense.

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF PSYCHIATRIC INFORMATION. IF PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release **VIDA Family Practice, PC**, its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

_____ _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE **DATE**