VMP, LLC
expanding genetic horizons...

Voice: 404.720.0820
Fax: 866.744.5665
www.vmpgenetics.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS OR MEDICAL INFORMATION

This form is required when an individual (or their guardian or personal representative) requests that VMP release medical records or medical information to someone other than the patient.

Please understand that releasing medical records have become a very complex process due to all the rules and regulations that are involved. We prefer patients release their own records. Patients seen within 14 months are supplied their medical records for free and records are released to a 3rd party for a $25 fee (each). If the patient has not been seen within 14 months there is a charge of $25 to provide to the patient and $50 for each 3rd party. Please go to our website to pay online or you may mail us through our secure patient portal your information.

Patient Name: ____

Date of Birth: ______________________ Today's Date: ______________________

Phone Number: ______________________ Email: ______________________

By signing this Authorization, I authorize Virtual Medical Practice, LLC to disclose certain protected health information about me to the party listed below.

1. **The following is the information to be disclosed pursuant to this Authorization.**

   ❑ Notes & Lab Reports ❑ Notes only ❑ Laboratory Reports only ❑ Other: ______________________

   *Medical Records from another health care provider in your record will not be provided. Please see them for release.

2. **The following person(s) or classes of persons are authorized to receive the information**
   Include name, facility or dept name, address; telephone & fax number of where information is to be mailed, fax, or securely emailed.

   Release to: ____

   Fax Number: ____

   Full Address: ____

3. **The disclosure is for the following purpose** ❑ At the request of the patient ❑ Other: ______________________

4. **This Authorization will expire on** : ______________________
   (If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.)

Re-disclosure: I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization.

In order for my revocation to be effective, VMP must receive the revocation in writing. The revocation must include:

- The patient's name, address and identification number, if applicable
- The effective date of this Authorization
- The recipient's of the PHI according to this Authorization
- The patients desire to revoke this Authorization
- The intended date of the revocation, if later than the Health Center's receipt of the revocation, and
- The patient's signature

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VMP will accept written revocations of this Authorization via:

- Certified US Mail
- Fax at this number: 866.744.5665

ALL revocations must be sent to VMP to the attention of the Privacy Officer. A revocation is not effective until the later of the date it is received by the Privacy Officer or any other date specified in the revocation.

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

I do not have to sign this Authorization in order to receive treatment from VMP. In fact, I have the right to refuse to sign this Authorization.

I authorize the use and/or disclosure of my PHI as described above. I have read the contents of this Authorization, and I fully understand and accept its terms.

____ ______________________

PLEASE PRINT - PATIENT NAME **DATE OF BIRTH**

____ ______________________

PLEASE PRINT –NAME OF PARENT/GUARDIAN OF PATIENT **RELATIONSHIP TO PATIENT**

____ ______________________

SIGNATURE – PATIENT OR PARENT/GUARDIAN **DATE SIGNED**

VirtualMedicalPractice, llc
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