



Patient Name: \_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request that my protected health information from \_\_\_\_\_ to be disclosed to:

Recipient name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax (healthcare provider only): \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary Date:                       | <input type="checkbox"/> Consultation Reports Date:                                 |
| <input type="checkbox"/> History and Physical Date:                    | <input type="checkbox"/> Radiology Report Date:                                     |
| <input type="checkbox"/> Operative Report Date:                        | <input type="checkbox"/> Laboratory Report Date:                                    |
| <input type="checkbox"/> Test Results Date:                      Type: | <input type="checkbox"/> EKG Report Date:   |
| <input type="checkbox"/> Emergency Room Record Date:                   | <input type="checkbox"/> Other (please specify what document(s) and date of service |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

- |   |                                |                             |                                 |
|---|--------------------------------|-----------------------------|---------------------------------|
| Alcohol, Drug, or Substance Abuse Records | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Dates: |
| HIV Testing and Results                   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Dates: |
| Mental Health or Psychotherapy Records    | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Dates: |
| Covering the period of health from:       | <input type="checkbox"/> dates | <b>To:</b>                  |                                 |

OR All past, present and future encounters/visits.

- |   |   |   |  |   |                                |
|---|---|---|--|---|--------------------------------|
| <b>Purpose for requesting information</b>                 | <input type="checkbox"/> Legal                | <input type="checkbox"/> Insurance                      | <input type="checkbox"/> Personal            | <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Other |
| <b>Disclosure Format (paper is default if not marked)</b> | <input type="checkbox"/> US mail-paper format | <input type="checkbox"/> FAX (healthcare provider only) | <input type="checkbox"/> Email Secure format |   |                                |

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees .
- I have the right to revokethis authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the above address. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire on the following date/event/condition:** \_\_\_\_\_  
If I fail to specify any expiration date/event/condition, this authorization will **expire one year from the date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by national confidentiality rules.

Prime Virtual HealthCare & Wellness (PVHCW)

Boca Raton, Florida

