vitalia
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Request & Authorization to Release Confidential Medical Information

Patient Name: (Printed): _____ **DOB:**_____
Address:_____ **Phone:**_____

From: _____

_____
Physician/Clinic Phone Fax

To: _____

_____
Physician/Clinic Phone Fax

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Dr. Bassett does not offer reimbursement for records received. We will only release information pertaining to office visits with Dr. Bassett or labs ordered by her (not information received from other practitioner)

************Please release the following information************

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ **Health records (inclusive of: history, physical exams)**
_____ **Labs**
_____ **Diagnostic Imaging**
_____ **Other:**_____

For the following periods: ☐ **Previous** ___ **Months** ☐ **Since first office visit**

The following must be initialed to be released:

_____ **HIV/AIDS test results and related information, including high risk behavior documentation**
_____ **Drug/Alcohol diagnosis, treatment, or referral information.**
_____ **Mental Health information**

By signing below I agree to release of the aforementioned health information. I understand that I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance where refusal to sign means I will not receive health care services, is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. ***There will be a fee for providing copies.***

_____ _____
Signature of Patient/Authorized Representative Date

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