Voice: 404.793.7800
Fax: 866.744.5665
www.vmpgenetics.com

CONSENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO VMP

______________________________ ______________ ______________
Patient's Name | Patient's Date of Birth | Phone, including area code

I,____ **hereby request and authorize**
(Print name of Parent/Legal Guardian or Patient (if 18 years of age or older)

____
(Facility and/or Physician that is to release the records with their address, city, state, zip and fax number)

to release the following information from the medical record of the patient named above. I hereby request and authorize the following medical information be released to:

VMP, LLC
Attn: Frances D Kendall, MD
5579 Chamblee Dunwoody Rd, Suite 110
Atlanta, GA 30338
Phone #: 404.793.7800 Fax #: 866.744.5665 Email: info@vmpgenetics.com

This Form Expires 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.)

Please release all of the following checked information:

	□ History and Physical Exam Report	X Neuropsychological Reports
X All Geneticist Notes	X Summery Reports	X Pathology Reports
□ Routine Consultations	X Laboratory Reports	□ Progress Notes
X Diagnostic Summery Report	X Last Clinical Follow up Note	□ Radiology Report
X Discharge Summary	□ Medication Records	□ Therapy Notes
□ Emergency Room Record	X MRI Reports, no film	□ Other:

- All information I hereby authorize to be obtained from this facility will be held in strict confidence. I place no limitations on history or illness (including HIV and/or AIDS) or diagnostic and therapeutic information, including any treatment of alcohol, drug abuse, or psychiatric disorders.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department of the facilities listed above. I understand that the revocation will not apply to any health information that been already been released in response to this authorization and that I may re-disclose information in writing.
- I consent to the inspection of the above information by the above named agency/person and/or to the furnishing of a Photostat or other copies.
- I hereby release the disclosing facility above and its officers, directors, agents and employees from any and all liabilities, responsibilities, damages, losses and claims that might arise from the release of the information authorized above.
- In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily consent to the disclosure of this medical information to the individual or agency named above.

____ ______________
Signature of Patient or Legal Guardian as named above | Date