VMP, llc
Expanding Genetic Horizons

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AUTHORIZATION TO RELEASE MEDICAL RECORDS OR MEDICAL INFORMATION

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 at the prevailing fee set by the State of GA. If the patient has not been seen within 14 months, the prevailing fee will apply to the patient and for each 3rd party to receive records.

Patient Name: _____

Date of Birth: _____ Today's Date: _____

By signing this Authorization, I authorize VMP (Virtual Medical Practice, LLC) to disclose certain protected health information about me to the party listed below. I understand that my health record may include information relating to genetics, my DNA, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol and drug abuse.

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. **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.)

I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing to VMP. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary and may refuse to sign this authorization. I need not sign this form in order to assure treatment. I may inspect or copy the information disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I authorize the 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 –NAME OF PARENT/GUARDIAN OF PATIENT **RELATIONSHIP TO PATIENT**

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