Authorization to Release Protected Health Information (PHI)

I hereby request to obtain a copy of my medical records from VGM GROUP, INC. under federal law 45 CFR104-191, also known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I am entitled to such access upon written request.

Patient Name: Date of Birth:

Patient Address: City: State: Zip:

Patient Phone: Patient Email:

*If the address the records are to be sent or discussed is different than the patient listed above, please indicate below:

Name: _____

Address: _____ City, State, Zip:_____

Purpose of authorization (Check all that apply):

- ☐ Obtain a Copy of my Personal Medical Records
- ☐ Obtain a Copy of my Personal Billing Records
- ☐ Allow individual designated below to speak to a VGM GROUP, INC. authorized representative and/or obtain documentation regarding my Protected Health Information (PHI):

Name (First and Last) Relationship to Patient

Address City State Zip

Authorization ends (Check One):

◯ On (date) _____ ◯ When the following event occurs: _____

Your Rights

You have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been completed based upon your initial authorization. You may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, you must send written notice to the appropriate disclosing party.

Uses and disclosures already made based on your initial authorization cannot be taken back.

It is possible that information used or disclosed with your authorization may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Rules.

You can request a copy of this authorization.

Policies and Restrictions on Viewing or Copying Personal Medical Records

- Under federal law, we may only provide a "Designated Record Set" of your Personal Medical Records.
- This Designated Record Set only includes medical records we physically store and maintain on our premises, and only includes those portions of medical records that "are used to make decisions about patients."
- You are allowed to designate a proxy/guardian/caregiver to speak or request information on your behalf.
- We are NOT able to provide you with:
  - *Items not maintained in legal health records*
  - *Education records exempt from HIPAA*
  - *Psychotherapy notes*
  - *Data involved in criminal, civil, or administrative actions*
  - *Records put together in anticipation of legislation*
- If an Electronic Health Record (EHR) system is in use, you may request and obtain an electronic copy of your medical records. You may also instruct us to send an electronic copy of your medical records to any third party you specify in writing.
- We may legally deny your request for access to your medical records, without opportunity for appeal, in the following circumstances:
  - *You are an inmate in a correctional institution, and access would endanger your health and safety or the health and safety of anyone else in the facility.*
  - *Your records were generated in the course of ongoing research, and disclosure would jeopardize the research. (You must have agreed, in writing, to such a restriction previously. And if so, your right of access will be restored at the conclusion of the research)*
  - *Your records are subject to federal Privacy Act protections in accordance with 5 USC 552a.*
  - *The information was obtained from someone under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source.*
- We may legally deny your request for access to your medical records, but with an opportunity for appeal, if such access is reasonably likely to endanger the life or physical safety, or cause substantial harm to you or another person.
- Our Policy is to respond to and fulfill your request within thirty (30) days.
- If you are simply viewing your Designated Record Set, we reserve certain days and times for such viewing.
- If you are requesting copies of your Designated Record Set, fees will be charged for the copies. Our fees are:
  - *VGM GROUP, INC. will notify the requestor of applicable charges at the time of completion, based on quantity and labor requirements.*

Signature of Patient Date

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor:_____ years of age

☐ Patient is unable to sign due to:

Signature of Authorized Representative

Name of Authorized Representative

Date

Description of Authorized Representative's Authority

****If other than patient, or other than parent if patient is a minor, Proof of Guardianship or Power of Attorney is required to be included with this form.**