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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO ANOTHER PARTY

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I voluntarily authorize and direct Vital Health Institute to disclose my health information during the term of this Authorization to the recipient hat I have identified below:

Vital Health Institute ("VHI")
15055 Los Gatos Blvd., Suite 250
Los Gatos, CA 95032
Phone: 408-358-2511 Fax: 408-358-1009

TO:

Name: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

By requesting all or part of your records, it is understood that VHI will release all of the health information that we, the provider have in our possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the VHI may hold.

Please indicate which medical records you would like released to the above party:

Please note that there may be a fee associated with copying and mailing your records. VHI will contact you for payment before records will be released. This authorization will remain in place for one year. Allow up to 2 weeks to process.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient Signature

Date