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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: ___________________________________ Date of Birth: ______________

Social Security Number: ___________________ Phone: _________________________

Address: ____

I, _________________________________ HEREBY AUTHORIZE

____
Name of Hospital / Physician / Facility

PHONE: __________________________ FAX: ___________________________

TO RELEASE INFORMATION SPECIFIED BELOW FROM MY MEDICAL RECORDS COVERING

THE DATES OF SERVICE ______________________ TO ________________________

THE INFORMATION WHICH IS CHECKED (X) BELOW IS TO BE RELEASED TO:

Vital Health Institute
1199 Main Ave., Suite 217
Durango, CO 81301
Phone: 970-317-2297
Fax: 408-358-1009
Email: michelle@vitalhealth.com

CHECK OFF ITEMS BEING RELEASED

- ☐ **OPERATION AND PATHOLOGY REPORTS**
- ☐ **DIAGNOSTIC TESTS**
- ☐ **LABORATORY / X-RAY RESULTS, excluding HIV**
- ☐ **HISTORY AND PHYSICAL REPORTS**
- ☐
- ☐ **OTHER: __ ______________________**

AND REQUEST THAT THE CHECKED RECORDS BE FAXED NO LATER THAN ___________

This authorization for release of medical records form is valid now and will remain in effect until ________________. Furthermore, I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Patient:____ Date: _____________

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