



Patient's Request Form for PHI to be sent to Vori Health

Patient's Name: _____ Patient's Date of Birth: _____
Patient's Address: _____ Patient's Phone Number: _____

Patient's email address: _____

I (the patient described above), or my authorized representative, request that my PHI maintained by _____ (provider) and as detailed herein be provided to Vori Health in accordance with the instructions below.

PHI Requested:

- ☐ Entire Medical Record
☐ Only certain documents from the medical record: *(please check the applicable boxes below)*

☐ Clinician Visit Notes	☐ Imaging Reports
☐ Hospital/ Ambulatory Surgery Center Records	☐ Laboratory/Pathology/Other Test Reports
☐ External Clinical Reports	☐ Other <i>(specify)</i>

Date(s) of Service of PHI Requested: From Date: _____ To Date: _____
(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: If the PHI you are requesting contains information about drug/alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information, by signing this Patient's Request to Access PHI form, you confirm that you are requesting access to this information, unless you otherwise state here:

PHI specified above should be provided:

☒ To the following person/entity: Vori Health
(Specify name of person/entity to whom you would like your PHI to be sent)

PHI should be provided by either of the following methods:

☐ Emailed by secure/encrypted PDF attachment via email to the following e-mail address: hello@vorihealth.com

OR

☐ Faxed to the following fax number: (901) 284-2536

☐ Other: *(specify)*

ACKNOWLEDGMENT:

I understand that e-mail may not be secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI by e-mail I acknowledge that I understand and accept these risks.

I understand that I may be charged a reasonable fee for the costs of labor for copying or supplies as permitted by HIPAA Privacy Rule and state law.

I understand that I may revoke this authorization in writing at any time, except where disclosures have already been made based upon my original permission. Revocation must be made in writing and to the disclosing party.

I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I have the right to refuse to sign this authorization.

Printed Name: _____

Signature: _____

Date: _____

Access Requested By: *(Check One)*

☐ Patient

☐ Authorized Representative

If this request is signed by the patient's authorized representative:

Please specify your authority to act on behalf of the patient: _____

Please be sure to attach supporting documentation.

Effective date: 4 May 2021

Approved by Mary I. O'Connor, MD, Chief Compliance Officer

Approval History

Date	Notes	Editor(s) / Author(s)
08/31/2021	Policy Approved	Mary O'Connor, CCO
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