

Authorization to Disclose Protected Health Information to Family and Friends

Patient/Plan Member Information
Patient Name: _____
Date of Birth: _____
Address: _____
City/State/Zip: _____
Medical Record # (optional): _____

Instructions: Complete entire form. If **any** section is incomplete, this form may be invalid.

Your privacy is important to us and we want to protect it as much as possible. By signing this form, you authorize Vori Health to disclose information as requested to the individual you list below.

Release Information To

Person Authorized to Receive Information (list one individual per form)	Name (first, middle, last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:		
The individual named above is authorized to obtain information in the following manner(s) (check all that apply):		
☐ Verbally: for example, via phone, face-to-face.		
☐ Patient Online Services: when the above-named individual submits a proxy request form through Patient Online Services, this access will be enabled.		
☐ Written or printed format: for example, medical record copies or the patient appointment guide.		
☐ Vori Health's electronic medical record systems: if the above-named individual is a Vori Health staff member with permissions to access the electronic health record, the individual can view your protected health information _____ electronically.		

I understand that the information to be released may include my past, present, or future health information including billing, treatment, records related to behavior and mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider or facility releasing the information.

The provider or facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. The patient has a right to inspect and receive a copy of the material disclosed. This authorization will not affect any previous authorizations that I have signed. If I want to change any previous authorizations, I must submit a request in writing to have any previous authorizations revoked.

This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **This form is for patients 18 years of age or older.** The patient must sign and date this form.
- **If the patient is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.

_____ Legal Guardian or Conservator _____ Health Care Advocate (Health Care POA)

Signature (required)		Date (required)	
Printed Name of Person Signing (if not patient) (First, Middle, Last)			
Patient Street Address			
City	State	Zip Code	Phone

Send your form to:

Fax:

Email: billing@vorihealth.com