



VIRTUALMEDICALPRACTICE, LLC

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Purpose: This form is used when an individual (or his/her personal representative) requests that VMP (Virtual Medical Practice, LLC) disclose PHI (Protected Health Information) outside of TPO (treatment, payment, business operations) to another person or entity outside VMP.

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Phone Number: _____ Email: _____

Mailing Address: _____

By signing this Authorization, I authorize Virtual Medical Practice to disclose certain protected health information about me to the party listed below.

1. **The following is the information to be disclosed pursuant to this Authorization. Please be advised that a charge may be imposed for copying/faxing/shipping any medical information.**

Notes & Lab Reports Notes only Laboratory Reports only

Other: _____

Medical Records from another health care provider will not be provided unless you check this box

2. **The following person(s) or classes of persons are authorized to receive the information** - include name, facility or dept name, address and telephone number of person or entity where information is to be mailed regular post.

a. You understand that we will fax or email your information and you are aware that by doing so may compromise your privacy.

i. _____ :Initial By marking your initials to the left, you do not want us to fax or email your information.

b. For pick-ups, please check here . Please call our office to make arrangements.

Name/Address: _____
Use another sheet if necessary

Phone: _____ Fax/Email: _____

3. **The disclosure is for the following purpose** (check one and complete as needed):

At the request of the patient Other: _____

4. **This Authorization will expire on :** _____

(If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.)

Re-disclosure: I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization.

Continued.....

Mail - 5579 Chamblee Dunwoody Rd, Suite 110, Atlanta, GA 30338
Clinic - 3400 Old Milton Pkwy, Bldg A, Ste 500, Alpharetta, GA 30005
Voice: 404.720.0820 Fax: 404.601.9931 www.virtualmdpractice.com



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In order for my revocation to be effective, VMP must receive the revocation in writing. The revocation must include:

- The patient's name, address and identification number, if applicable
- The effective date of this Authorization
- The recipient's of the PHI according to this Authorization
- The patients desire to revoke this Authorization
- The intended date of the revocation, if later than the Health Center's receipt of the revocation, and
- The patient's signature

VMP will accept written revocations of this Authorization via:

- Certified US Mail
- Fax at this number: 404.601.9931

ALL revocations must be sent to Virtual Medical Practice to the attention of the Privacy Officer. A revocation is not effective until the later of the date it is received by the Privacy Officer or any other date specified in the revocation.

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

I do not have to sign this Authorization in order to receive treatment from VMP. In fact, I have the right to refuse to sign this Authorization.

I authorize the use and/or disclosure of my PHI as described above. I have read the contents of this Authorization, and I fully understand and accept its terms.

PLEASE PRINT - PATIENT NAME

DATE OF BIRTH

PLEASE PRINT -NAME OF PARENT/GUARDIAN OF PATIENT

RELATIONSHIP TO PATIENT

SIGNATURE - PATIENT OR PARENT/GUARDIAN

DATE SIGNED