



Today's Date: _____

I here by authorize (name & address) _____

to furnish to VISTA HEALTHCARE, LLC protected health information and medical records pertaining to medical history, mental or physical condition, services rendered, or treatment of (name of patient)

OR

I here by authorize VISTA HEALTHCARE, LLC to furnished (name & address of requestor) _____

protected health information and medical records pertaining to medical history, mental or physical condition, services rendered, or treatment of (name of patient)

OR

I here by request to access my protected health information or the protected health information of a patient in which I am acting as the patient's representative.

This authorization is limited to the following medical records and types of information. Please initial information you would like released:

_____ Emergency Room Record	_____ Behavioral Health Record, including psychotherapy notes
_____ Operative Report	_____ HIV Test Results
_____ Consultation Report	_____ Aids Records
_____ Discharge Summary	_____ Other (specify): _____
	_____ Alcohol or Drug Abuse
	_____ Laboratory Results

The requester may use the medical records and types of information authorized for only the following purposes:

I understand I will pay a fee of \$0.25 per copied page, and this fee due at the time copies are picked up or before mailed, for purposes other then treatment or payment.

This authorization shall become effective immediately and shall remain in effect until (date) ___/___/____.

A photocopy or facsimile of this authorization shall be as good as the original.

I understand that the requester may not further use or disclose the protected health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have the right to revoke this authorization in writing.

I understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: YES NO



Signature: _____ Date: _____ Time: _____ AM/PM
(patient/representative/spouse*/financially responsible party*)

If signed by other than patient, indicate relationship: _____

Witness: _____

Patient's Name: _____

Address: _____

Date of Birth: _____ Date of Service: _____

Social Security Number: _____ Phone Number: _____

*(*See below for additional instructions)*

*A spouse or financially responsible party may only authorize release of protected health information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

*For HIV test results: This authorization may be signed by a person other than the patient only under the following circumstances:

1. The patient is under twelve (12) years of age, or, as a result of his/her physical or mental condition, is incompetent to consent to the HIV antibody blood test or the release of the test results; and
2. The person who authorizes the release of the test results is lawfully authorized to make health care decisions for the patient, e.g., an agent appointed in a power of attorney for health care; the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative (see chapters 2 and 22 of the CHA Consent Manual).

NOTE: The authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. This authorization also released any alcohol or drug abuse records; or, psychiatric records per the Lanterman-Petris-Short Act; or, HIV/AIDS information documented within the patient record, including HIV test results. This authorization for use or disclosure of protected health information is being requested of you to comply with the terms of the Privacy Rule, Title 45, Code of Federal Regulation, Parts 160 and 164.