3125 Route 9W Suite-201 New Windsor, NY 12553 77 Tarrytown Road Suite-1E White Plains, NY 10607 Phone # 914-502-3998 Fax # 866-942-1556

 4 Pine West Plaza-Suite 403 Albany, NY 12205 6 Chelsea Place, Clifton Park, New York 12065 Phone# 518-691-0732 Fax# 866-942-1556

 **HIPAA AUTHORIZATION FORM**

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised

to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_/\_\_\_/\_\_\_, give permission to VITALITY PHYSICIANS GROUP PRACTICE to:

 Patients Name

 ☐ Use/Receive the following protected health information from

 And / Or

 ☐ Disclose the following protected health information to

**Name, Phone Number, Fax Number, Email Address of Entity to Release/Receive Information**

Examples: PCP, Internist, Family Practitioner, Pediatrician or Obstetrician, Family Member etc.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number/Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be received and/or disclosed (check all that apply):**

☐ Psychiatric Records ☐ Psychotherapy Records ☐ In-Patient Hospital/Facility Records

☐ Discharge Summary ☐ Consultation Notes (Including Medical History & Physical Exam)

☐ Lab Reports ☐ Alcohol/Drug Treatment ☐ Medication List ☐ Scheduling Rights (to verify/schedule appts)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This protected health information is being used or disclosed for the following purposes:

☐ Coordination of Care ☐ At My Request ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization expires**: 1 year from date signed

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy

Regulations (HIPPA), the information described above may be disclosed to other individuals or institutions and no longer protected

by these regulations.

**You may refuse to sign this authorization**. By checking this box ☐ your refusal to sign will not affect your ability to

obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health

information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to

VITALITY PHYSICIANS GROUP PRACTICE. Your notice will not apply to actions taken by the requesting person/entity

prior to the date they receive your written request to revoke authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Personal Representative Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Witness Signature