VISION & CONCEPTUAL DEVELOPMENT CENTER
PERSONALIZED CARE. COMPASSION. RESULTS.

AUTHORIZATION TO RELEASE OR REQUEST MEDICAL RECORDS

(Health Insurance Portability and Accountability Act of 1996)

Patient Name: _____ **Date of Birth**: _____

Name of Guardian: _____

Relationship to Patient: _____

By signing below, you agree to the following statement:

I hereby authorize the Vision and Conceptual Development Center to receive, use, and disclose my (the patient's) protected health information as chosen below, to the selected recipient(s) in the manner specified. I understand this release will expire no later than one calendar year from the date signed, or as per my choosing to revoke this authorization by completing the statement at the bottom of this document.

Print Name: _____

Signature:_____ **Date:** _____

The information may be used / disclosed for the following purpose(s):

□ At patient's request □ For employment
□ For patient's healthcare □ For payment / insurance

□ Other: _____

Specific types of records:

□ All Records □ X-ray / Radiology □ Pharmacy / Prescription
□ Laboratory / Pathology □ Billing □ Reports / Abstract summaries

□ Other: _____

Check if we are allowed to:

☐ Disclose Records ☐ Request Records

Authorized Contact(s) (Who the VCDC is allowed to contact)

Name: _____

Company / Business: _____

Specialty / Occupation: _____

Phone: _____ **FAX:** _____

E-mail: _____

Address: _____

Revocation Statement

As of _____ I, _____, choose to revoke this authorization.
Date Print Patient Name