Victor Healthy Living
the place for healthcare

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AUTHORIZATION FOR TRANSFER OF MEDICAL INFORMATION

Patient Name: _____ SS #: _____ DOB: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____

☑ I hereby authorize Victor Healthy Living to obtain my health information from:

Name of Provider/Facility: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Dates of Treatment being disclosed: ❑ All ❑ From: _____ To: _____

Reason for Disclosure: ❑ Transfer of Care ❑ Consultation ❑ Insurance ❑ Other _____

Information to be Disclosed:

❑ Complete Health Record
❑ Include alcohol & drug information
❑ Include information related to sexually transmitted diseases (HIV may require additional documentation)
❑ Include information related to mental health, including but not limited to depression and anxiety

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

❑ 1 year from the date in which, I, or my legal representative, signs this authorization;

❑ upon the happening of the following event: _____
(Example: "Upon release of the above records.")

I understand that

- my right to healthcare is not dependent on this authorization.
- I may revoke this authorization at any time by providing written notice to Victor Healthy Living at the address shown above.
- if the facility, organization, or person receiving this information is not a health care or medical insurance provider covered by privacy regulations, this information could be disclosed.
- release of HIV/AIDS information may require additional documentation.

Signature: _____ Date: _____

If signed by the patient's legal representative:

Printed name of representative: _____

Relationship to the patient: _____