All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name | Date of Birth | Medical Record Number

Address | City | State | Zip | Telephone Number | Email Address

I authorize the use and disclosure of health information about me as described below:

Vista Physician Group **Medical Records Phone (847)360-4307** **Fax (847)360-4247**

Facility Authorized to Release my Health Information

Agency or Individual(s) Authorized to Receive my Health Information | Fax Number

Address | City | State | Zip | Telephone Number

Health Information that may be used / disclosed is limited to the following:
☐Progress Notes ☐Emergency Room Record
☐Discharge Summary ☐History & Physical ☐Consultation(s) ☐Lab ☐Pathology Report
☐Operative Note(s) ☐Imaging/X-ray ☐X-Ray Reports ☐Entire Record
☐Other (*specify*): _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ to (date):_____ Account Number _____
From (date): _____ to (date):_____ Account Number _____

Health Information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
☐Treatment/Consultation ☐At Request of Patient ☐Research ☐Marketing ☐Billing or Claims Payment
☐At Request of Employer ☐Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-ray films, slides, tracings, strips, etc.
I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include genetic testing, alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** complied during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐Yes ☐No If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.
This authorization will automatically expire 60 days after the date of signature below (except as indicated below), unless an earlier data is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refused to sign the authorization may result in denial of care or coverage.
NOTICE TO RECEIVING AGENCY OR INDIVIDUAL – This information is to be treated in accordance with (HIPPA) privacy regulations.

Patient's or Authorized Personal Representative's Signature* | Date | Time

Relationship to Patient / Authority to Act on Patient's Behalf | Interpreter, if utilized

Witness's Signature | Date | Time | Expiration Date or Event

☐*Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.
☐Electronic copy requested.