

# VIVO INFUSION

## RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

**Patient Information:**

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

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**Release to:**

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

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**REASON FOR REQUEST:**

\_\_\_ Legal Issue \_\_\_ Personal Use \_\_\_ Transfer of Care \_\_\_ New Provider Request \_\_\_ SSA/Disability

**Check Only Information That Is Requested**

- Complete Record
- Labs (ordered by Vivo Infusion Providers only) Date: \_\_\_\_\_
- Infusion Treatment Record Date: \_\_\_\_\_
- Infusion Orders
- Other: \_\_\_\_\_

I request and authorize the above-named health care provider to release the information specified above to the organization named on this request. I understand that the information to be released may include information regarding condition(s) other than the one you are being treated for at this facility.

I understand that:

1. My signature on this form is strictly voluntary. If you are a Personal Representative, you must provide legal proof of this designation.
2. I may revoke this authorization any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. If the requestor or receiver is not a health plan or health care provider the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations
4. The patient/personal representative can request a copy of the entire record once per year at no cost. If you request more than one copy during the year you will be charged a minimal duplication cost.
5. Please be advised that e-mailing records is not considered a secure method of record release and we cannot guarantee their security once it leaves our server.

**Signature of Requestor:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_**Contact Phone Number:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_**Delivery Instructions:**

- Call requestor for pickup when records are ready
- Mail records directly to the person or organization specified above
- I authorize \_\_\_\_\_ (name) to pick up my Protected Health Record. Relationship to Patient: \_\_\_\_\_ *ID required for pickup*
- FAX/email record to: \_\_\_\_\_

Please return this form to:

Clinical Operations Manager or FAX/Mail to Vivo Infusion, Attn: Medical Records

FAX: 855-600-0374 Mail: 1726 Cole Blvd, Suite 250, Lakewood, CO. 80401