VERO RADIOLOGY ASSOCIATES

Vero Radiology Associates, LLC
3725 11th Cir, Vero Beach, FL 32960
Phone: 772-562-0163 x132 Fax: 772-410-0303
Email: IR-medrec@ccf.org (general)
Email: IR-WIC@ccf.org (Women's Center)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

MR#

Please Print

Last Name_____ First Name_____ Middle Name_____

Date of Birth _____Address_____City _____

State _____ Zip _____Contact Phone ( ) _____

I hereby authorize Vero Radiology Associates to □ release/□ obtain protected health information, including copies of the medical record of the above named patient □ to/□ from the following:

Mail records_____ **Pick up records**_____ **Email records**_____

Name of Person/Facility_____

Street _____ City _____ State_____ Zip _____

Contact Phone _____ Fax _____ email_____

Purpose for Release: □ Continuation of Medical care □ Personal □ Legal □ Insurance □ Disability □ School

Is the request for PHI for the purpose of marketing and/or does it involve the sale of PHI? □ Yes □ No

Will the recipient receive financial remuneration in exchange for using or disclosing this information? □ Yes □ No

Information to be released

Requests for Radiology Images and Copies of medical records can be provided: □ On paper
(the following require separate waiver) □ CD □ Via non-encrypted email. You may view your medical record on site by appointment only. Contact the Medical Records department to schedule an appointment.
772-562-0163 x132

I request the following:

Test result Date(s) of service _____

Type of test :
□ X-Ray □CT □ MRI/MRA □ Nuclear Medicine
□ Bone Density □ Mammogram □ Ultrasound

_____
_____
_____
_____

*Appointment date:*_____

Date faxed: _____

Release of Information Requiring Specific Consent:

The following categories of information may be included in your medical record and WILL NOT be released unless you indicate specific authorization by INITIALING each appropriate category.

_____ Abortion _____ Behavioral/Mental Health _____ Alcohol/Drug Abuse _____ Domestic Violence _____
Sexual Assault _____ Genetic Testing _____Sexually Transmitted Disease _____ HIV/AIDS Results/Treatment

I understand that:

- I may revoke this authorization at any time by submitting a written notice to VRA at the address listed above. The revocation will be effective upon VRA receipt of my written notice, except that it will not have any effect on any action already taken by VRA in reliance on this authorization.
- Once VRA has disclosed my health information to the recipient, VRA cannot guarantee that the recipient will not disclose my health information to a third party and it may no longer be protected by the HIPAA privacy rule.
- This authorization will automatically **expire in 6 (six) months** unless otherwise specified.
- I may refuse to sign this authorization and that is strictly voluntary.
- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I will receive a copy of this signed authorization.

_____ _____

Signature of Patient or Authorized Representative Date

You MUST provide/attach proof of your authority to act on behalf of the patient (other than parent). You must also be listed on the patient's HIPAA form.
You MUST provide/attach a picture identification to validate your identity. _____Government issued ID, ____passport, or _____driver's license.

AUTHORIZATION TO RELEASE MEDICAL RECORDS ELECTRONICALLY

Disclaimer regarding ROI form (for email or electronic format): I understand that the CD is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that non-encrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with non-encrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive my health information on a CD or USB flash drive or by non-encrypted e-mail, I am acknowledging and accepting these risks.

_____ _____

Signature of Patient or Authorized Representative Date