VECTOR Health & Wellness, LLC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PRINT LEGIBLY AND COMPLETE ALL HIGHTLIGHED SECTIONS

Return form by mail, email or secure fax.

LEGAL Last Name: _____ LEGAL First Name: _____

LEGAL Middle Initial: _____ Previous Name(s) Used: _____

Date of Birth: _____ Last 4 digits of Social Security Number:_____

Mailing Address: _____

_____

Phone: _____ Email: _____

I authorize VECTOR Health & Wellness to send my medical records to the provider below:

Practice/Provider Name:_____

Practice Address: _____

Phone: _____ Fax: _____

_____ (Initial) I understand that medical records related to HIV/AIDS, sexually transmitted infections (STI/STDs), sexual/reproductive health, mental health, substance use/abuse, gender non-conformity and hormone therapy are considered especially sensitive.

_____ (Initial) Due to the nature of care provided at VECTOR Health & Wellness, I understand that my medical records may contain sensitive information along with information related to routine care.

_____ (Initial) I *explicitly* authorize the release of my medical records to the provider listed above with the full knowledge that sensitive information may be included. *(If you do not want sensitive information released, please call the clinic for further guidance.)*

_____ (Initial) I understand that, due to privacy regulations, VECTOR canNOT re-release or send some/all of the medical records they obtained from other providers on my behalf.

I request records be sent from the last (circle one): 1 year 3 years complete record

This authorization expires in one (1) year. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name (if not the patient): _____ Relationship to patient: _____

Staff Initials: _____ Date of ROI Receipt/Review: _____ Updated 8/22/25 - SH