VECTOR Health & Wellness, LLC
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Fayetteville, AR 72704
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AUTHORIZATION FOR TO RELEASE HEALTH INFORMATION TO ANOTHER PROVIDER/ENTITY

LEGAL Last Name: _____ **LEGAL** First Name: _____

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

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

Address: _____

_____

Phone: _____ **Email:** _____

I authorize VECTOR Health & Wellness to *SEND* medical records *TO* the provider below:

Practice/Provider Name:_____

Address (or email): _____

Phone: _____ Fax: _____

_____ **(initial) **I understand that these records are considered especially sensitive and authorize them to be released to/by VECTOR Health & Wellness, LLC for use in determining ongoing treatment related to these conditions.**

Information to be released:

- ☐ Office Notes — Dates _____
- ☐ Labs/Imaging/Studies — Dates _____
- ☐ Procedures — Dates _____
- ☐ STI/STD Records — Dates _____
  - ☐ Including HIV related records**
- ☐ Other Records_____ — Dates _____

OR: ☐ Entire Medical Record **with / without** ☐ HIV records**

_____ (initial) I understand that VECTOR can NOT re-release or send some or all of the medical records they obtained from other providers.

This authorization expires in one year OR on the following date: _____

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: _____

Witnessed by: _____ Signature: _____ Date: _____