VECTOR Health & Wellness, LLC
1267 N Steamboat Dr Ste 3, Fayetteville, AR 72704
Phone: 479-316-6565 | **Secure Fax: 479-316-0331**
Email: info@vectorhealthnwa.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (REVERSE ROI)

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 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 (1) 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: _____________

Staff Initials: ________________ Date of ROI Receipt/Review: ________________ Updated 9/29/23 - SH