



VECTOR Health & Wellness, LLC
1267 N Steamboat Dr Ste 3
Fayetteville, AR 72704
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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 OBTAIN medical records FROM 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**
- Mental Health Records** _____ Dates _____
 - Including psychotherapy notes
- Other Records _____

OR: Entire Medical Record **with / without** HIV records** Mental Health records**

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: _____