VirtualConsultMD

REQUEST FOR RELEASE OF MEDICAL INFORMATION FORM

PATIENT INFORMATION

Full Name:		DOB:		Phone:	
Address:					
City:		State:		Zip Code:	

REQUEST FORM

1. This Request is valid for SIXTY (60) DAYS from the date of signature below, unless specified otherwise here: _____
2. I have the right to revoke this request at any time by writing to the healthcare provider or entity listed below in ***Section 6*** *("Request By").* I also understand that I may revoke this request except to the extent that action has already been taken.
3. I understand that signing this request is voluntary. Virtual Consult MD will provide treatment to me even if I do not sign the request to obtain my records from the individual or entity listed below in ***Section 7*** *("Request From"),* unless the sole purpose for the service is dependent upon obtaining the information requested.
4. If I am requesting the release of medical information from the individual or entity listed below in ***Section 7*** *("Request From")*, then Virtual Consult MD is prohibited from re-disclosing of such information without my written authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of recipients to who may receive or use my medical information without a written authorization.
5. I understand that Information used or disclosed pursuant to this request may be re-disclosure by Virtual Consult MD and this re-disclosure may no longer be protected by either federal or state law.
6. REQUEST BY: Name and address of healthcare provider or entity receiving this requested information ***(choose one)***:

☐ **Virtual Consult MD, LLC**
4770 Covert Avenue, Suite 101
Evansville, Indiana – 47714
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
109 US Highway 66 E, Suite 151
Tell City, Indiana – 47586
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
11 NE 3rd St
Washington, IN 47501
Tel: (812) 848-2322 / Fax: (812) 727-5469

7. REQUEST FROM: Name and address of individual or entity sending this requested information:
Name of Individual/Entity: _____ **Phone:** _____
Address: _____ **Ste/Apt:** _____ **Fax:** _____
City: _____ **State:** _____ **Zip:** _____
8. Request Records for the Following Dates of Service ***(choose one)***:
☐ All Dates of Service **OR** ☐ Only Dates of Service; From: _____ To: _____
9. Specific Information Requested to be Released ***(check all that apply)***:
☐ **Entire Medical Records**; including psychotherapy notes
☐ **Medical Records Only**; excluding psychotherapy notes.
☐ **Psychotherapy Notes Only**; including session notes and treatment plans
☐ **Substance Abuse Records**; not a part of medical record
☐ **Other Records**; please specify _____
10. Purpose of Record Request ***(choose one)***:
☐ Treatment / Continued Care ☐ FMLA Application ☐ Legal / Litigation
☐ Other, specify: _____

BY SIGNING BELOW, I, THE ABOVEMENTIONED OR LEGAL REPRESENTATIVE, AUTHORIZE THIS REQUEST TO OBTAIN THE SPECIFIED MEDICAL INFORMATION AS SET FORTH ON THIS FORM IN ACCORDANCE WITH THE PRIVACY RULE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT I HAVE THE RIGHT TO OBTAIN A COPY OF THIS REQUEST FORM.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW **DATE SIGNED**