AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Identification (please print)

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Contact Phone Number: _____
(Month / Day / Year) *(Phone number with area code where individual can be reached in case of questions)*

Address: _____
(Street)

_____
(City) (State) (Zip)

Medical Record Number (MRN), if known: _____

This document authorizes VytlOne or its subsidiaries or affiliates to release certain protected health information of the individual named above to the following individual or entity:

Authorized Individual / Entity: _____

Address: _____

Phone Number: _____ Email address: _____

Purpose for the Release of Information: _____

Relationship to Patient:

☐ Self ☐ Agent (Power of Attorney) ☐ Caregiver ☐ Healthcare Provider ☐ Insurance Carrier

☐ Legal Counsel / Attorney ☐ Other (please describe): _____

The following documents or information may be shared with the Authorized Individual/Entity listed above:

Medication/prescription history for the time period of ___/____/____ to ___/___/___

Billing/account information for the time period of ___/____/____ to ___/___/___

Other: _____ for the time period of ___/____/____ to ___/___/___

IMPORTANT: Sensitive health information or diagnoses may be included in a release of medical records. Please initial next to the following sensitive diagnoses if you permit us to release this information to the Authorized Individual/Entity:

_____HIV/AIDS _____Sexual Health _____Substance Use Disorder _____Mental illness

This authorization will remain valid until the earlier of five years from the date of signature; the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the date entered here: _____/_____/_____.

Any information disclosed under this authorization may be subject to further disclosure by the recipient and no longer protected under state or federal protected health information law.

VytlOne cannot rely upon this document to grant or authorize power of attorney decisions on your behalf. Please consult your legal representative if you require a power of attorney.

Acknowledgement of Authorization to Release Protected Health Information

I understand this authorization is voluntary and that I can refuse to sign it.

I understand that refusing to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

I understand I can request a copy of this authorization at any time.

I understand that I can revoke this authorization at any time in writing to the address below, unless information was already disclosed under this authorization. Information released prior to revoking this authorization will not be further disclosed.

VytlOne
Attn: Privacy Compliance
320 S. Polk St. Suite 200, Amarillo, TX 79101
Or Fax toll free: (806) 324-5493
Or Email: compliance@VytlOne.com

Patient signature: _____ Date: _____

Authorized Party Identification, if applicable

Authorized Representative signature: _____ _____Date: _____

Authorized Representative printed name: _____

Authorized Representative's legal authority to release patient information:
☐ Parent of minor patient ☐ Legal Guardian* ☐ Power of Attorney* ☐ Healthcare Power of Attorney*

We are committed to protecting our patients' privacy. Authorized representatives are asked to submit valid and active legal documentation demonstrating legal guardianship, durable power of attorney or healthcare power of attorney to support their authority to release the patient's protected health information, if not already on file.