HIPAA Authorization for Release of Information – Compound Release

Patient Name:	**Patient Date of Birth:**
Virginia Physicians Inc. is authorized to release the protected health information described below for the above-identified patient.	
Entity to Receive Information Check each person or class of persons that you approve of to receive information.	**Description of Information to be Released** Check each type of information that can be shared with the person or class of persons listed to the left.
☐ Voice Messages at _____	☐ Appointment Reminders ☐ Lab Results ☐ Other:
☐ Email or Text Messages For email and/or text messaging, I understand that information may not be sent in an encrypted manner and could result in unauthorized access by third parties.	☐ Appointment Reminders ☐ Lab Results ☐ Discuss Treatment
☐ Spouse or Partner _____	☐ All Health Information Except:
☐ Other Individual _____	☐ All Health Information Except:
☐ Other Individual _____	☐ All Health Information Except:

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

Signature of Patient or Personal Representative: **Date:**

Description of Personal Representative's Authority (attach necessary documentation:

☐ Mother ☐ Father ☐ Legal Guardian ☐ Power of Attorney ☐ Other:

Date this Authorization Expires: _____