Authorization for Release of Protected Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Facility/Doctor Name: ____________________

Address: ____________________ City, ST, Zip: ____________________

Phone Number: ____________________ Fax: ____________________

Facility/Doctor Name: ____________________

Address: ____________________ City, ST, Zip: ____________________

Phone Number: ____________________ Fax: ____________________

Facility/Doctor Name: ____________________

Address: ____________________ City, ST, Zip: ____________________

Phone Number: ____________________ Fax: ____________________

I, Patient Name: ____________________ Date of Birth: ____________________,
authorize you to disclose the Protected Health Information described below to:

Retro Health, LLC
1001 S. Mays St. Suite 205, Round Rock, TX 78664
Phone: (844) 573-3733 Fax: (833) 483-1565
Email: Virtualinfo@RetroHealth.com

The complete history records in your possession concerning my illness and treatment for **Continuation of Care**:

______ All Health Information
______ History & Physical
______ Progress Notes
______ Past/Present Medications
______ Consultation Reports
______ EKG/Cardiology Reports
______ Diagnostic Test Reports
______ Patient Allergies
______ Pathology/Lab
______ Discharge Summary
______ Radiology Reports & Images
______ Operations Reports

Please release the information for the following dates/time-period: ____________________

Date Records Needed By: ____________________ Please Mail, Fax, or Email (All Secure)

My initials below indicate special permission to release any information other than indicated above:

______ Drug, Alcohol, or Substance Abuse Records
______ HIV/AIDS Test Results and Treatment
______ Genetics (including test results)
______ Mental Health Records

This authorization shall be in force and effective for 6 months from the date of signature. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Retro Health, LLC. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

____________________ Self____________ ____________________
Signature of Patient or Legal Representative | Relationship to Patient | Date

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