Ronald Vicencio MD
4953 Van Dyke Rd Lutz FL 33558
Ph 813 544-1465 Fax 813 537-8848
Info@V-Medcare.com

Authorization to Use or Disclose Protected Health Information

I hereby authorize ______________________________ to use or disclose the following information from the health records of the individual whose name is described below:

Patient Name: ______________________________ Date of Birth: ____________

Address: ______________________________

Phone Number: ____________________ Social Security #: ____________________

I authorize the above-named facility to release medical, mental, alcohol and/or drug abuse, HIV testing, AIDS, eating disorders or other medical information of a sensitive nature to the following individual(s) or organizations(s):

VMedcare Fax 813 822-0023

This information for which I am authorizing disclosure will be used for the following purpose: Ongoing Medical Care

Dates of Service to be released: Last 3 yrs, but please release all colonoscopy and Cardio Tests

The type of information to be used or disclosed is as follows:

- ☐ Abstract/Chart Summary
- ☐ Discharge Summaries
- ☐ History/Physical Reports
- ☐ Operative / Procedure Reports
- ☐ (Colonoscopy) (All)
- ☐ Consult Reports
- ☐ Immunizations
- ☐ EKG/Echo/Heart Cath (ALL)
- ☐ Progress Notes
- ☐ Lab/ X-ray / Imaging Results
- ☐ ER Records
- ☐ Other: ____________

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

Signed: ______________________________ Date: ____________

☐ Patient or authorized person ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Photo ID Checked

Witness: ______________________________ Date: ____________

Copied by: ____________________ Pages copied: ________ Date: ____________