RELEASE OF MEDICAL RECORD FORM

Patient Name:_____ **Date of Birth**:_____

Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services ("**PHI**"). Under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), certain uses or disclosures will be made **only with your written authorization**. Therefore, this authorization must be completed for the healthcare provider identify below to release your medical records containing PHI to MVM Health, LLC ("**MVM Health**").

AUTHORIZATION

I, the undersigned patient, authorize my medical records, or the portion of them specified below, to be released from:

Practice/Provider Name: _____

Address: _____ City, State: _____

Zip Code: _____ Practice Phone: _____ Practice Fax: _____

I request and authorize my medical records, or the portion of them specified below, to be released to MVM Health at:

MVM Health, LLC
296 East Brown Street, Suite C
East Stroudsburg, PA 18301

Phone: (223) 213-2084 Fax: (223) 213-2057

I authorize the release of my health information for the following:

- ☐ New or Continued Medical Care
- ☐ Legal Purposes
- ☐ Insurance Purpose
- ☐ Personal Injury
- ☐ Workers Compensation
- ☐ Other (*specify*): _____

The information that can be disclosed to MVM Health includes:

- ☐ Last 3 Office Visit Notes/Progress Notes
- ☐ All Imaging Reports: X-Rays, MRI's, CT's
- ☐ EMG/Nerve Conduction Test Reports
- ☐ Medical History, hospitalizations
- ☐ Discharge Letter (if patient was under pain management or receiving opioid medications)
- ☐ Mental health records, diagnosis, and/or treatments (if needed)
- ☐ Other (*specify*):_____

This authorization will be in full force and effect for until the death of the patient unless otherwise indicated below.

☐ Expiration Date:_____

The PHI is being disclosed for the following purpose (*write "at my request" if there is no specific purpose or you do not wish to specify the purpose*):

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to MVM Health's Office Manager. I understand that a revocation is not effective to the extent that MVM Health has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, MVM Health may use or disclose my PHI in accordance with MVM Health's Notice of Privacy Practices.

I understand that PHI disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that MVM Health will not condition my treatment on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)