AMERICAN VITALITY NETWORK

Fax 312-674-7605
Phone 847-917-0707

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following Information

Patient Name: _____

Address: _____

_____

Phone: ( ) _____

SSN: ___-___-____ Date of Birth: ___/___/____

I authorize the custodian of record or other person / entity at _____

To disclose / release the following information* (check all that apply)

- ☐ All Records
- ☐ Laboratory/Pathology Records
- ☐ X-Ray/Radiology Records
- ☐ Billing Records
- ☐ Abstract/Summary
- ☐ Pharmacy/Prescription Records
- ☐ Other (describe specifically) _____

* *Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug / alcohol abuse or sexually transmitted disease, you are herby authorizing disclosure of this information.*

These records are for services provided on or about the following date(s): _____

Please send the records listed above to:

Name: RejuveNATION Medical Concierge by AVN

Address: 616 w Fulton Suite 711

Chicago, IL 60661

Phone: (847) 917-0707

Fax: (312) 674-7605

This information may be used/disclosed for each of the following purposes:

- ☐ At My Request (Only the patient can check this box)
- ☐ For My Health Care
- ☐ For Payment/Insurance
- ☐ For Employment Purposes
- ☐ Other: _____

This authorization shall expire no later than: ___/___/____ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of Patient (or patient's personal representative) | Date

_____ _____

Printed Name of Patient (or Representative) | Representative's Authority to Sign for Patient

(i.e. parent, guardian, power of attorney for healthcare, executor)

A copy of this signed authorization must be given to the individual