VIRAPEL™
Bioidentical Hormone Replacement Therapy

Authorization for Release of Medical Information

According to HIPPA and Governmental rules all patients are asked to sign this release form indicating that you understand that our office follows all HIPAA rules with respect to protected health information. I hereby authorize the use/disclosure of my health information as described below, including records treatment, prognosis and diagnosis. Records which may be released include: all medical records, pertaining to my medical history.

I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy delivered in person, by mail, email or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to receive and use this information:

- Pharmacy (Name, & Phone #'s allergies only) _____
- Significant Other or Family Member: _____

☐ I further authorize you to provide to and discuss with the staff of Virapel, and its representatives, any confidential information with respect to my medical condition or treatment, either formally or informally.

- I understand that my health care will not be affected if I do not sign this form.
- 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 staff at Virapel. 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 contest a claim under my policy. If I do not revoke this authorization, it will automatically expire six months from its date.
- I understand this is not in relation to requesting medical records for me for another physician.
- I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) or its physicians', employees, or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

_____ _____

Signature of Patient Date