Email or mail completed form and attachments to:

VARP, Inc. Administration
Attn: Compliance Officer
1100 N. D Street
San Bernardino, CA 92410

patient-records@varpinc.org

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Are you the Patient?

☐ Yes ☐ No, I'm the patient's legal/personal representative*

Note: If you're not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.

Patient Information

Patient Name:		Date of Birth:	
Address, City, State, ZIP:			
Patient Phone:		Email:	

Who do you want to request records from?

Healthcare Provider or Facility Name:	
Address, City, State, ZIP:	
Phone:	Fax:

Where do you want the records sent to? *Note: We can release information only to who you authorize.*

☐ **Check this box if records are being sent to the patient only. No further action in this section needed.**

Recipient Name:			
Recipient Address, City, State, ZIP:			
Recipient Phone:		Recipient Email:	

What is the reason for requesting records?

☐ I'm moving and/or switching providers ☐ Getting a second opinion ☐ Seeing a Specialist
☐ Military Enlistment ☐ Personal Use ☐ Other reason: _____

What treatment dates of service are you looking for?

Specify an approximate* date range – Start: ____/____/____ to End: ____/____/____

Date range doesn't have to be exact. Enter dates to the best of your ability.

What types of records would you like?

Additional Consent Requirement

I understand that the following records are protected under state and/or federal law and cannot be disclosed without my explicit written consent and signature unless otherwise provided for by the regulations.

Do we have permission to release the following protected information that may be contained in your records? Please check all that apply below.

☐ HIV Test Results ☐ Substance Use/Drug Abuse Records
☐ Mental Health Records ☐ Genetic Testing Results

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Is there a deadline for this request?

By law we have up to 30 days to fulfill your request. However, if you have an urgent need for an upcoming appointment, please let us know. We will do our best to honor your deadline.

☐ Yes, I have a deadline. Date needed: _____ ☐ No, just as soon as possible.

How would you like us to release the records? **Must select one (1) option ONLY*

☐ Email (encrypted)
☐ CD (password protected)
☐ CD in-person
☐ Paper by Mail
☐ Paper in-person

Expiration Date

This authorization shall become effective immediately and remain in effect for one (1) year from the date signed below unless specified here*: _____

Your Rights Under the Law

I understand that my patient records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

If you are someone other than the patient: In addition to a Photo ID, please include a copy of valid supporting documentation that gives you authority to request records on behalf of the patient. (Exception: Parents of minor patients).

Acceptable forms of supporting documentation include:

- Advanced Healthcare Directive (must be in effect at time of requesting records)
- Death Certificate
- Executor of the Estate (for deceased patients only)
- Power of Attorney (must include a provision that allows medical decision-making and/or release of medical records)
- Power of Attorney for Health Care (must include a provision that allows release of medical records)
- or some other form of documentation (subject to final review)

SIGNATURE AND DATE *(As required by law)*

SIGNATURE: _____ Date: _____ Time: _____
(Patient or Legal/Personal Representative*)

*If signed by someone other than the patient, print name and specify relationship to the patient:

Name: _____ Relationship: _____

Photo ID: You must include a legible copy of your photo ID or other government-issued ID along with the authorization form for identity verification purposes. If picking up the records in-person, you will be asked to provide your photo ID at that time.