RELEASE OF INFORMATION

(Required items are in BOLD print — *Please do not use correction fluid or tape*)

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

Previous Names:_____ **Social Security #:** _____/_____/_____

Address:_____ **City, State & Zip Code:** _____ **Phone #:** _____

I, _____ **authorize** Vibra Health Laboratory

Name of Patient or Name of Legal Representative — *Name of Organization/Provider to Release Information*

1307-A Allen Dr.	Troy, MI 48083	(248) 846-0663	(248) 846-0673
Address	*City, State and Zip Code*	*Phone Number*	*Fax Number*

to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

_____

Name/Organization to Receive Information

_____	_____	_____	_____
Address	*City, State and Zip Code*	*Phone Number*	*Fax Number*

1. **Specific information to be disclosed**
   ☐ Lab Reports

   Other:_____

For the following date(s) of treatment or medical conditions: _____

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: _____
   _____
   _____

3. **I am requesting this information be released for the following purpose:**
   ☐ Personal Use
   ☐ Other:_____
4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
5. I understand there may be a fee to process this release of information.
6. This authorization will automatically expire on: _____/_____/_____ or one year from the date of my signature.
7. Vibra Health Laboratory will not condition my continued treatment upon my signing this authorization, except for research-related treatment.
8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.
9. I hereby agree to indemnify and hold Vibra Health Laboratory, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____ _____

Patient or Patient's Legal Representative's Signature — *Date*

_____ _____

**Relationship If Other Than Patient* — *Witness*

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

*☐ **AUTHORITY ATTACHED** (In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization).

Please fax or mail completed form along with a copy of the front and back of your drivers license to:

Vibra Health Laboratory
1307-A Allen Dr.
Troy, MI 48083
Fax: (248) 846-0673

Results will be mailed to you within 3-5 business days upon receipt of form.