



**Patient Authorization for Release of Medical Records  
And Disclosure of Protected Health Information**

By signing this authorization, I authorize VeriTrust to retrieve, and/or disclose, as well as transmit certain Protected Health Information (PHI):

Doctor's Name \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Legal Guardian / Parent authorizes release of medical records (same as above if patient is self):

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Driver's License # or Government Issued ID: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This authorization permits VeriTrust to retrieve, use and/or disclose to me, my legal guardian or the physician of my choosing; medical or health information records. Additionally, this authorization permits VeriTrust to deliver records to the identified address via 3<sup>rd</sup> Party (ex. Fedex, UPS, DHL) shipment. When my information is disclosed pursuant to this authorization, it may be subject to re-disclosure by patient or patient's representative and may no longer be protected by the federal HIPAA Privacy Rule.

**VeriTrust must receive this signed authorization prior to release of any medical or patient records along with any associated fees that will be incurred to process this request;**

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_  
Print Name of Patient or Legal Guardian Date

**ORIGINAL SIGNATURE MUST BE RECEIVED IN ORDER FOR RECORD TO BE RELEASED  
SEND FORM TO PO BOX 22737 HOUSTON, TX 77227  
(Please include a photocopy of a government issued photo ID)**