AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION AND PATIENT-DIRECTED ACCESS REQUEST

(VERITAS ONE, INC.)

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION

Patient Name: **Test Three**

Date of Birth: 1979-01-01 Medical Record #: _____

Address: _____

Preferred Phone #: 555-555-5555 Email: test.three@test.com

PURPOSE (check one): ■ Medical Care ■ Insurance ■ Legal ■ Personal ■ School ■ Other: _____

B. PERMISSION TO SHARE

Records FROM (Disclosing Provider/Facility):

Site/Location: (Will be filled in based on provider selection)
Practice Name: _____

Send records TO (Designated Recipient):

Veritas One, Inc. — acting as my agent to receive/consolidate and deliver records to me
Fax (secure): [Will be provided] Phone: [Will be provided]

C. INFORMATION TO BE RELEASED (check all that apply; specify dates)

■ ALL RECORDS (Designated Record Set), ALL DATES (includes clinical + billing; radiology reports & images)
■ Medical record abstract (H&P, operative reports, consults, test reports, discharge summaries)
■ Clinic / visit notes Date(s): _____
■ Laboratory Date(s): _____
■ Radiology REPORTS and IMAGES (DICOM/CD/portal acceptable) Date(s): _____
■ Billing / claims Date(s): _____

D. SENSITIVE INFORMATION — RELEASE ONLY IF INITIALED BY PATIENT

■ HIV/AIDS testing, diagnosis, or treatment — Initials: TT
■ Genetic testing/results — Initials: TT
■ Substance Use Disorder records (42 C.F.R. Part 2) — Initials: TT

NOTICE: Federal rules prohibit further disclosure of Part 2 records unless expressly permitted by the patient's written consent or as otherwise allowed by Part 2.

■ Mental/behavioral health information (non-psychotherapy notes) — Initials: TT
■ Psychotherapy notes (HIPAA-defined) — SEPARATE specific authorization required — Initials: TT

E. ACKNOWLEDGMENTS, EXPIRATION, AND REQUIRED HIPAA STATEMENTS

- **Right of Access / Form & Format:**
  I am requesting access and directing transmission of my records to Veritas One. Please provide the copy in the form and format requested if readily producible, otherwise in a readable alternative format agreed upon (45 C.F.R. §164.524(c)(2)). Please act as promptly as possible and no later than 30 days from receipt (one 30-day extension only with written notice). Fees must be reasonable and cost-based.
- **Voluntary/No Conditioning:**
  My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization (subject to HIPAA's limited exceptions).
- **Revocation:**
  I may revoke this authorization at any time by written notice to Veritas One and to the Disclosing Provider, except to the extent action has been taken in reliance.
- **Redisclosure:**
  Information disclosed to the recipient may be redisclosed and may no longer be protected by HIPAA, except as otherwise restricted by law (including 42 C.F.R. Part 2 for SUD records).
- **Expiration:**
  This authorization expires 6 months (180 days) from the date signed unless I specify an earlier date/event.

SIGNATURES

[redacted]

Patient Signature Date: November 13, 2025

Print Name: Test Three

If signed by Personal Representative:

Name/Relationship/Authority: _____

_____

Signature Date: _____

FACILITY USE ONLY

Date received: _____ Completed by: _____ Delivery method: ■ Fax ■ Electronic ■ Mail Completion date: _____