



HIPAA AUTHORIZATION, RECORD RELEASE, ELECTRONIC RECORD SHARING & PDMP CONSENT

425 Old Newman Road, Suite 100
Frisco, Texas 75036
(469) 277-0089

PATIENT AUTHORIZATION

I authorize Vascular 360 Medical Clinics, its physicians, providers, staff, contractors, affiliated facilities, and business associates to obtain, release, request, receive, review, and exchange my protected health information ("PHI") for purposes of treatment, payment, healthcare operations, surgical planning, medication management, coordination of care, referrals, and related healthcare services.

AUTHORIZATION TO OBTAIN OUTSIDE RECORDS

I authorize Vascular 360 Medical Clinics to request and obtain medical records, imaging records, laboratory records, operative reports, pathology reports, consultation notes, medication records, prescription history, pharmacy records, hospital records, and other healthcare-related information from my physicians, hospitals, pharmacies, imaging centers, laboratories, urgent care centers, surgery centers, healthcare systems, and other healthcare providers involved in my care.

ELECTRONIC HEALTH INFORMATION EXCHANGE

I understand and authorize that my medical information may be shared electronically between healthcare providers, hospitals, imaging centers, laboratories, pharmacies, surgery centers, health information exchanges, electronic medical record systems, e-prescribing systems, and other authorized healthcare platforms when available for purposes of treatment, coordination of care, medication safety, continuity of care, healthcare operations, and related medical services. This electronic exchange may include interoperability systems, health information exchanges (HIEs), EMR integrations, e-prescribing networks, secure messaging systems, and other legally permitted healthcare communication technologies.

PDMP AND PRESCRIPTION HISTORY CONSENT

I understand that state and federal laws, regulations, and prescribing standards may require healthcare providers to review Prescription Drug Monitoring Program (“PDMP”) databases and related prescription history systems prior to prescribing certain controlled substances. I authorize Vascular 360 Medical Clinics and its providers to access, review, and monitor my prescription history through state PDMP systems, pharmacy benefit manager databases, pharmacy records, medication history services, e-prescribing systems, and other legally authorized medication monitoring systems for purposes of patient safety, controlled substance prescribing compliance, medication reconciliation, fraud prevention, and medical treatment. I understand that this authorization may be necessary if controlled substances are prescribed as part of my medical treatment.

DISCLOSURE OF INFORMATION

I authorize Vascular 360 Medical Clinics to disclose relevant protected health information to other physicians, hospitals, pharmacies, imaging centers, laboratories, surgery centers, consulting providers, referral providers, home health agencies, insurance carriers, billing entities, and other healthcare organizations as reasonably necessary for my treatment, payment, healthcare operations, referrals, scheduling, coordination of care, and related medical services consistent with HIPAA and applicable law.

REVOCACTION

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance upon this authorization.

ACKNOWLEDGMENT

I acknowledge that I have read and understand this authorization and voluntarily consent to the release, receipt, review, exchange, and electronic sharing of my medical information as described above.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Responsible Party (if applicable): _____

Relationship to Patient: _____

Date: _____