Valley Health Systems (VHS) – Authorization for Release of Information

Patient Name Last First MI Maiden/Other

DOB Mo Day Year SS# Account#

Current Address City State/Zip

Day Phone (with Area Code) Mobile Phone Work Phone

( ) I authorize VHS to **release information TO:**

Name of Provider OR Facility:

Address

City, State, Zip

Phone or fax number with area code

( ) I authorize VHS to **obtain information FROM:**

Name of Provider OR Facility:

Address

City, State, Zip

Phone or fax number with area code

Check the description(s) that apply to your request:

Release the following information:

( ) for only one provider – list doctor's name: _____

( ) for only one location – list location name: _____

( ) for ALL locations & providers for the above listed facility

LIST DATE RANGE of records needed: _____

DO NOT WRITE IN "ALL" – list specific date or year range

( ) Office visit notes
( ) Diagnostic testing results
( ) Lab Reports (includes urine)
( ) Surgery/Hospital Notes
( ) Obstetric Records
( ) Optometry
( ) Dental Records
( ) Outside Consult/Referral
( ) Drug Screens
( ) Other (specify):

IF you want any of this information released, you must check which to be released and sign in this box – OR none of these will be released.

I specifically authorize the release of information related to:

( ) Substance Use & Substance Use Disorder
(includes substance use disorder treatment records)
( ) Mental Health Services
( ) HIV related information (AIDS testing & anything related)
( ) Sexually transmitted disease/Communicable disease information
( ) Genetic Testing information

X_____

Signature of patient/legal guardian/authorized person

NOTE – Therapy/Psychotherapy Notes are NOT included with this authorization – requires a separate, specific release.

Information is to be released for the following purpose(s) – check any that apply:

( ) Changing Physicians
( ) Legal
( ) Worker's Compensation
( ) Consultation/Second Opinion
( ) School
( ) Continuing Medical Care
( ) Insurance
( ) Other (must specify): _____

I understand the following:

- **This authorization will expire 1 year after I have signed this form.**
- **I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received except to the extent action has already been taken on the original request.**
- **The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.**
- **VHS may not condition treatment or payment on whether I sign this authorization.**
- **If I receive substance use disorder treatment services at VHS, such information is protected under 42 CFR Part 2.**

I have had an opportunity to review the contents of this authorization. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

X_____ X_____

Signature of Patient/Legal Guardian/Authorized Person Date of Signature Witness Signature

X_____

Records Received by Date Relationship to Patient

Office Use: Date completed:	Completed by:	ID presented:	Fee collected: $_____