Site contact information

RELEASE OF INFORMATION FORM:

Name _____ DOB _____ SSN _____

Address_____ Phone _____

I authorize Valley Health to (select one): ◯ release information to ◯ receive information from

Name of provider/facility _____

Address_____Phone_____

TIMEFRAME & TYPES OF INFORMATION TO BE RELEASED: **Fax#:** _____

List specific dates/years ("all" is not permitted): _____

If you only want a certain physician/provider's records released rather than all, list the name here: _____

Categories (check all that apply): ◯ office visit notes ◯ diagnostic testing results ◯ labs including drug screens ◯ outside consult/referral ◯ surgery/hospital notes ◯ optometry ◯ dental ◯ other: _____

Purpose of Disclosure: ◯ continuity of care ◯ changing physicians ◯ legal ◯ personal ◯ other: _____

****BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING**:**

1) I understand that my health records to be released/disclosed may contain sensitive information regarding or relating to sexually transmitted diseases/communicable diseases, HIV/AIDS, genetic testing, mental health conditions and services (***EXCLUDING*** *PSYCHOTHERAPY NOTES – REQUIRES A SEPARATE, SPECIFIC AUTHORIZATION*), and substance use & substance use disorder treatment (***INCLUDING*** *MAT Program records*)
   I AUTHORIZE ALL SENSITIVE CATEGORIES OF INFORMATION TO BE RELEASED (INCLUDING MAT, IF APPLICABLE) UNLESS OTHERWISE INDICATED BELOW:
   ***List what you DO NOT want RELEASED*:** _____
2) This authorization will expire 1 year after I have signed this form.
3) 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.
4) The information used before this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
5) Valley Health may not condition treatment or payment on whether I sign this authorization.
6) If I receive substance use disorder treatment services, including the MAT program at Valley Health, such information is protected under 42 CFR Part 2.

Signature of patient/legal guardian/representative: _____ Date _____

Relationship if not patient: _____

*(*If patient is deceased – must provide documentation of MPOA or Administrator/Executor of Estate*)*

Witness signature: _____ Date _____