

Patient Name	Last	First	MI	Maiden/Other
DOB	Mo	Day	Year	SS#
Address	City			State/Zip
Day Phone (with area code)	Mobile Phone			Work Phone

<b>Choose One</b>	<input type="checkbox"/> I authorize <b>VHS</b> to release information <b>TO</b> :	<input type="checkbox"/> I authorize <b>VHS</b> to obtain information <b>FROM</b> :
	Name of provider or facility _____	Name of provider or facility _____
	Address _____	Address _____
	City, State, Zip _____	City, State, Zip _____
	Phone or fax number with area code _____	Phone or fax number with area code _____

<b>Records</b>	<b>Release psychotherapy notes for the following dates:</b>  Dates: _____	<b>DATES must be filled in! Example: 2012 to 2017</b> <b><u>"ALL" is not permitted</u></b>
	<p>I understand my psychotherapy notes may include sensitive information such as reference to substance use &amp; substance use disorder, STD/communicable disease, HIV, and genetic testing. If I wish to exclude any of this information from release, I must specify below:</p> <p style="padding-left: 40px;">Specific information <b>not</b> to be released: _____</p>	

<b>Purpose</b>	<b>Information is to be released for the following purpose(s):</b>		
	<input type="checkbox"/> Changing Physicians	<input type="checkbox"/> Consultation/Second Opinion	<input type="checkbox"/> Insurance
	<input type="checkbox"/> Legal	<input type="checkbox"/> School	<input type="checkbox"/> Other (must specify): _____
	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Continuing Medical Care	

<b>Note</b>	<b>I understand the following:</b>
	<ul style="list-style-type: none"> <li>• This authorization will expire 1 year after I have signed this form.</li> <li>• 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.</li> <li>• The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.</li> <li>• VHS may not condition treatment or payment on whether I sign this authorization.</li> </ul>

<b>Sign Here</b>	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.		
	Signature of Patient/Legal Guardian/Authorized Person _____	Date _____	Witness _____
	Records Received by _____	Date _____	Relationship to patient _____

<b>Office Use:</b>	Date Completed: _____	by: _____	ID presented: _____	Fee collected: \$ _____
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