VALLEY HEALTH
Quality healthcare in your neighborhood.

Site contact information

Authorization for Release of Medical Records

PATIENT AND PROVIDER/FACILITY INFORMATION:

Name _____ DOB _____ SSN _____

Address_____ Phone _____

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

"Self" **OR** Name of provider/facility _____ Phone _____

Address_____ Fax _____

◯ Release information to MyChart (**ONLY if patient is releasing records to self**)

TIMEFRAME, TYPES, AND PURPOSE OF INFORMATION TO BE RELEASED:
List specific dates or timeframe ("all" is not permitted and must be filled in): _____

If you only want a certain provider's/site'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 clinicians ◯ consultation/second opinion ◯ insurance

◯ disability ◯ worker's compensation ◯ school ◯ legal ◯ personal ◯ other (must specify): _____

****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 deceased – must provide Administrator/Executor of Estate or Medical Power of Attorney*)*

Witness signature: _____ Date _____