# *Valley Professionals Community Health Center*

777 S. Main Street, Suite 100, Clinton, IN 47842
Phone: 765-828-1003; Fax: 765-828-1030

114 N. Division Street, Cayuga, IN 47928
Phone: 765-492-9042; Fax: 765-492-9048

201 W Academy Street, Bloomingdale IN 47832 Phone: 765-498-9000; Fax 765-498-9004

## *AUTHORIZATION TO RELEASE MEDICAL INFORMATION*

***Format type: _____ paper _____Electronic/disc***

**Patient Name**: _____**Date of Birth:** _____

**Patient Address:**_____
**Phone number:**_____

**I Authorize records be sent**
**FROM**: _____**Address**: _____
_____**Fax#** _____**Phone#** _____

**TO**: **Name of Person or Facility:**
**Street Address:**
**City, State, Zip:** _____ **Phone or Fax#**_____

**This authorization for Release of Information covers the period of healthcare from**_____ **to** _____

| **Purpose of Disclosure**: | **Information Requested**: |
|---|---|
| _____Referring Physician to Physician | ____Recent/Pertinent Laboratory Results |
| _____Continuing Care/Second Opinion | ____Radiology Reports |
| _____Personal ____Attorney | _____EKG report/tracing |
| _____Employer ____Disability | ____Any Pertinent Medical History |
| _____Insurance _____Other | ____All the above |

This authorization shall be in force and effect for __60__days at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the Vermillion-Parke Community Health Center. I understand that a revocation is not effective to the extent that the Vermillion-Parke Community Health Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may be no longer protected by federal or state law.

Vermillion-Parke Community Health Center will not condition my treatment, payment, enrollment in a health plan or eligibility benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I do not want the following information released/obtained:

| | | |
|---|---|---|
| _____Alcohol | _____Depression | _____Hepatitis |
| _____ Drugs | _____ HIV/AIDS | _____Sexually transmitted diseases |

_____ _____
Signature of Patient or Personal Representative/Relationship Date

_____
Signature of Witness Date