

Valley Professionals Community Health Center

201 W Academy St, Bloomington 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: _____ Fax# _____

Phone# _____

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

Purpose of Disclosure:

____ Referring Physician to Physician
____ Continuing Care/Second Opinion
____ Personal ____ Attorney
____ Employer ____ Disability
____ Insurance ____ Other

Information Requested:

____ Recent/Pertinent Laboratory Results
____ Radiology Reports
____ EKG report/tracing
____ Any Pertinent Medical History
____ 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 Valley Professionals Community Health Center. I understand that a revocation is not effective to the extent that the Valley Professionals 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.

Valley Professionals 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