Valley Professionals Community Health Center

1530 N 7th St, Suite 201, Terre Haute, IN 47807 Phone: 812-238-7631; Fax 812-238-7003

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:	**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 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