

Valley Professionals Community Health Center

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

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