VALLEY
Family Health Care
Healthy Families. Strong Communities.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:		Date of Birth:
Patient's Address:		Requestor's Name/Phone Number (if the requestor is not the patient):
PHI Recipient Name:	Address/City/State/Zip:	Phone Number: ( ) Fax Number: ( )
PHI Sender Name:	Address/City/State/Zip:	Phone Number: ( ) Fax Number: ( )

Purpose of Disclosure: ☐ School Use ☐ Personal Records ☐ Continuity of Care ☐ Other:_____

Format sent/received: ☐ Verbal ☐ Mail ☐ CD ☐ Paper ☐ Fax (30 pages or less) ☐ Pick up at VFHC_____

☐ Other: _____

***If dates are not indicated, the most recent two years of health records will be released.**

Description:	Date(s)*	Description:	Date(s)*	Description:	Date(s)*
☐ All Records NO Behavioral Health		☐ Physician Orders		☐ Educational Records	
☐ All Records WITH Behavioral Health		☐ Laboratory		☐ IEP/504/Testing	
☐ BH Records Only		☐ History & Physical		☐ ADHD	
☐ Diagnostic Studies		☐ Demographics		☐ Nutrition Notes	
☐ Progress Notes		☐ Medication Records		☐ EKG	
☐ Other(s):					

Please indicate here if you **DECLINE** to release any of the following **SENSITIVE INFORMATION** by checking the box and initialing each item: ☐ Genetic Testing (INITIAL)_____ ☐ HIV testing, HIV results or AIDS Information (INITIAL) _____
☐ Substance Abuse (INITIAL) _____

My signature on the bottom of this form signifies my acknowledgment and consent that the information released may contain the previous sensitive information.

I also understand that:

- This form is to authorize the medical information regarding the above identified person to be released.
- Valley Family Health Care cannot condition treatment or eligibility of benefits on whether the authorization is signed.
- Protected Health Information (PHI), once released, has the potential to be redisclosed by the recipient and is no longer protected by Valley Family Health Care.
- Please note that the request(s) may take approximately two weeks to process and, by law, 30 days are provided to process request(s).
- The patient may request a copy of this authorization at any time.
- This authorization is valid for one year from today's date unless revoked in writing.
- This authorization may be revoked at any time except for information released prior to the date of the written revocation. To REVOKE, SIGN HERE: _____ and DATE HERE: _____

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
(Patient or Legal Representative – Documentation Required) (Describe relationship if you are not the patient.)

VFHC STAFF SIGNATURE: _____ DATE: _____