



FAX: 866-257-8195 (email: ICS@valley-widehealth.org)

Behavioral Health Request Form for Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (____) _____

Name of Provider/Entity/Individual Requesting PHI: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (____) _____

In order to request patient Protected Health Information, the patient must sign a **HIPAA Compliant Authorization for Release of Information form** that specifically authorizes the Requestor to obtain their Protected Health Information.

Purpose for the Request: Coordination of Care Legal Personal Other: _____

Information to be Released:

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- | | | |
|--|---|---|
| <input type="checkbox"/> Outpatient Treatment Report | <input type="checkbox"/> Laboratory and Pathology | <input type="checkbox"/> Therapy Progress Notes |
| <input type="checkbox"/> Mental Health Intake and Updated Assessment | <input type="checkbox"/> Peer Notes | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychiatric Medication Service Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> UA/BA Results | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Case Management Notes | <input type="checkbox"/> Attendance | |
| <input type="checkbox"/> Entire medical records Dates: _____ To: _____ | | |

Sensitive Information

- | | |
|---|---|
| <input type="checkbox"/> Crisis Treatment Summary _____ | <input type="checkbox"/> WMU Treatment Summary _____ |
| <input type="checkbox"/> Substance and/or Alcohol Use _____ | <input type="checkbox"/> TRT Treatment Summary _____ |
| <input type="checkbox"/> ATU Treatment Summary _____ | <input type="checkbox"/> HIV/AIDs Related Information _____ |
| <input type="checkbox"/> Sexually Transmitted Disease _____ | |

Record requests may take up to 10 (ten) business days to complete. Please select how you would like to receive your records:

- Electronic Format - (CD/USB - \$15 Fee; E-mail or other encrypted electronic process - \$6.50)
- Paper Format (Page Fee \$18.53 pages 1-10, \$.85 pages 10-40, \$.57 pages over 40) plus postage and actual cost of mailing

Records sent for care coordination will be provided at no charge.

*Definition of Continuity of Care Record (CCR) – Electronic Summary of partial or all medical information contained within the electronic health record. Designed to allow ease of transfer of care from one entity to another and could potentially be imported into another electronic health record.

Signature of Person Requesting Information

Date