Valley-Wide Health Systems, Inc.
Your Health, Our Priority!

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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☐ Outpatient Treatment Report
☐ Mental Health Intake and Updated Assessment
☐ Psychiatric Medication Service Notes
☐ Psychiatric Assessment
☐ Case Management Notes
☐ Entire medical records Dates: _____ To: _____

☐ Laboratory and Pathology
☐ Peer Notes
☐ Discharge Summary
☐ UA/BA Results
☐ Attendance

☐ Therapy Progress Notes
☐ Diagnosis
☐ Treatment Plan
☐ Other: _____

Sensitive Information

☐ Crisis Treatment Summary ___
☐ Substance and/or Alcohol Use___
☐ ATU Treatment Summary___
☐ Sexually Transmitted Disease___

☐ WMU Treatment Summary___
☐ TRT Treatment Summary___
☐ HIV/AIDs Related Information___

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