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

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

# Authorization to Release and/or Exchange of Protected Health Information

**Patient Information**

Patient Name: _____Date of Birth: _____

Street Address _____City_____

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

**I authorize the holder of the health information:**

Name of Provider/Entity: _____

Street Address: _____ City: _____

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

Fax: (_____)_____

**To send/provide/disclose the health information listed below to the following:**

Name of Provider/Entity/Individual: _____

Street Address: _____ City: _____

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

Fax: (_____)_____

**Information to be released/requested/disclosed: Please check all that apply:**

☐ Immunization Results ☐ Discharge Summary ☐ Imaging Reports

☐ Preventive Exams ☐ Laboratory and Pathology ☐ Operative Notes

☐ Screening Tests ☐ Well Child/School Physicals ☐ Medication List

☐ Chronic Illness Management ☐ Diabetic Routine Care ☐ Other_____

☐ Please provide my entire medical record for dates:

From: _____ To: _____

**Sensitive Information - This information <u>will not</u> be released or requested unless <u>initialed</u> by the patient**

☐ Sexually Transmitted Disease Records _____ ☐ Genetic Testing ___

☐ Psychiatric Medications _____ ☐ HIV/AIDS Related Information _____

**Purpose of Request**

☐ Personal ☐ Continuity of Care ☐ Treatment ☐ Insurance ☐ Legal

☐ Patient Portal ☐ Other (specify) _____

**Family & Friends- My health information may be released/disclosed to the person above based on the following relationship**

☐ Spouse/Partner ☐ Personal Representative ☐ Parent/Guardian ☐ Other, _____

**Authorization Will Expire in One Year Unless Otherwise Indicated**

☐ Condition: _____Date_____

# Authorization to Release and/or Exchange Medical Records

Please select how you would like to receive your records:

- ☐ Electronic Format (CD) (**$15 Fee)**
- ☐ Paper Format (**Page Fee** $18.53 pages 1-10, $.85 pages 10-40, $.57 pages over 40) plus postage and actual cost of mailing
- ☐ Secure Email (**$6.50 Fee)**
- ☐ No Records Sent/Personal Health Information (PHI) Access Only.

Email Address: _____

**Records sent to another medical office 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.

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1. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand the revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
3. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. VWHS cannot condition treatment, payment, and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
4. I accept full financial responsibility for copying fees.

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian (Print): _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

(Required for all patients under the age of 18 unless otherwise allowed by law)

**Notice to Recipient of Confidential Information**

The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31).