Valley View Health Services Inc

Addiction Treatment Center

Internal Medicine

1001 9th Ave, Suite 2

Brackenridge, PA. 15014-1107

Tel (724) 393-1756 Fax (724) 604-7002

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME: _____ **BIRTHDATE:** _____

ADDRESS: _____ **SSN:** _____

_____

ENTITY TO RECEIVE INFORMATION

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ENTITY TO RELEASE INFORMATION

I authorize an appropriate representative of the below entity(ies) to release information from my medical records to the above stated entity. I understand that treatment, payment, enrollment, and/or eligibility for benefits may NOT be conditioned on my signing this form.

NAME: _____ **TEL:**_____

ADDRESS: _____**FAX:** _____

_____

INFORMATION TO BE DISCLOSED

For dates of treatment from _____to _____

□ **Complete First Party Benefits File (Consultations, Emergency Department Records, Labs, Radiology, Discharge Summary, Clinical/Progress Notes & Charts, Operative Reports, Physicians Orders, Business Records, Narratives, Billing Information and History).**

□ Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, Discharge Summary, ER Report).

□ Discharge Summary □ Mental Health Records □ Medication Records

□ Clinic/Progress Notes & Charts □ Emergency Dept. Records

□ Other _____

□ Consultation

□ Lab Results

□ Operative Reports □ Radiology (X-rays, MRIs, CT scans)

□ Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment.

✶ *I understand that the release of my health record(s) will be only for the purpose stated on this form and only those items indicated shall be released. I understand that once copies of these records are released the copies may be further disseminated and the above named entity releasing the record is not responsible for the protection of the copies of the records.*

REASON FOR THE RELEASE

_____

REVOCATIONS

I understand that I may revoke this Authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance of this Authorization. I understand that this Authorization is valid until the litigation of my case is completed. I agree that a photostatic copy of this Authorization shall be considered as effective and valid as the original.

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. Patient

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign Authorization because: _____

Signature: _____ Date: _____

(Parent/legal or personal representative)

Witness: _____ Date: _____

The fax that you have received contains highly confidential and federally protected health information. Any disclosure, dissemination, distribution or copying of this information is strictly prohibited and will be prosecuted under HIPPA (Health Insurance Portability and Accountability Act of 1996) and HITECH guidelines. If you feel you have received this information in error, please contact the sender immediately by the telephone number listed above to arrange the return or destruction of the information and all copies. Thank you.

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