Valley Professionals Community Health Center - Behavioral Health Release of Information

777 S Main St, Ste 100
Clinton In 47842
P: (765) 828-1003
F: (765) 828-1030

114 N Division St
Cayuga IN 47928
P: (765) 492-9042
F: (765) 492-9048

201 W Academy St
Bloomingdale IN 47832
P: (765) 498-9000
F: (765) 498-9004

Mobile School-Based
Health Center
P: (765) 592-6164

Format type: _____ paper _____ electronic/disc

Patient Information: (Please print)

Last name: _____ First Name:_____ Middle Initial:_____

Street Address: _____ City: _____ State: _____ Zipcode: _____

Phone: _____ Social Security number: _____ Date of Birth: _____

I authorize Valley Professional Community Health Center to Release, Obtain and Verbally Exchange Information to the following Health Care Provider or Facility: (Please print)

_____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State:_____ Zipcode: _____

Behavioral Health Record Consent: If signed, this consent authorizes Valley Professionals Community Health Center to release and obtain information about my behavioral health treatment including diagnosis, medication, and treatment recommendations, to the respective Health Care Provider or Facility referenced above.

Purpose: The purpose of this release is to assist with the continuity of care and facilitate treatment planning between Valley Professional Community Health Center and the Health Care Provider or Facility indicated above.

Expiration Date: This authorization will expire in 365 days unless otherwise indicated below:
____ This authorization will expire upon the following date or condition: _____
____ This authorization will expire 60 days past termination of services at Valley Professionals Community Health Center.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information previously released based on this authorization. Please fill out the section below to revoke this authorization to release information.

___ I am revoking this authorization. Date: _____ Signature: _____

Redisclosure Notice: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand that it may be redisclosed and no longer protected by Valley Professionals Community Health Center.

Refusal to Sign: I understand that I may refuse to sign this authorization, but my refusal to sign may affect the ability of the providers to provide me with the necessary treatment. If I refuse to sign this authorization I will still be seen for treatment unless the sole reason for treatment is to create protected health information for a third party, such as court ordered treatment.

Patient signature: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

If signed by Legal Representative, Provide the relationship to patient: _____

Staff signature as Witness: _____**Date:**_____