Valley Professionals Community Health Center

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201 W Academy St, Bloomingdale IN 47832 Phone: 765-498-9000; Fax 765-498-9004
1530 N 7th St, Suite 201, Terre Haute, IN 47804 Phone: 812-238-7631; Fax 812-238-7003
1810 Lafayette Ave, Crawfordsville, IN 47933 Phone: 765-362-5100; Fax 765-362-5171

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Format type: _____ paper _____Electronic/disc

Patient Name: _____**Date of Birth:** _____

Patient Address:_____
Phone number:_____

I Authorize records be sent
FROM: _____**Address**: _____
_____**Fax#** _____**Phone#** _____

TO: **Name of Person or Facility:** _____
Street Address: _____
City, State, Zip: _____ **Phone or Fax#**_____

This authorization for Release of Information covers the period of healthcare from_____ **to** _____

Purpose of Disclosure:

_____Referring Physician to Physician
_____Continuing Care/Second Opinion
_____Personal ____Attorney
_____Employer ____Disability
_____Insurance ____Other

Information Requested:

____Recent/Pertinent Laboratory Results
____Radiology Reports
_____EKG report/tracing
____Any Pertinent Medical History
____All the above

This authorization shall be in force and effect for __60__days at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the Vermillion-Parke Community Health Center. I understand that a revocation is not effective to the extent that the Vermillion-Parke Community Health Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may be no longer protected by federal or state law.

Vermillion-Parke Community Health Center will not condition my treatment, payment, enrollment in a health plan or eligibility benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I do not want the following information released/obtained:

_____Alcohol _____Depression _____Hepatitis
_____ Drugs _____ HIV/AIDS _____Sexually transmitted diseases

_____ _____
Signature of Patient or Personal Representative/Relationship Date

_____
Signature of Witness Date