

# Valley Professionals Community Health Center

VPCHC Cayuga  
703 West Park St  
Cayuga, In 47928

Phone: 765-492-9042 Fax: 765-492-9048

## Authorization to Obtain/Release Information

Patient name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### I authorize records to be sent:

From: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

To: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Format Type: Electric Paper

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 affect 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 Valley Professionals Community Health Center. I understand that a revocation is not effective to the extent that the Valley Professionals 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 no longer be protected by federal or state law.

Valley Professionals 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 disease

\_\_\_\_\_  
Signature of Patient or Personal Representative / Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness