

Valley Professionals Community Health Center

VPCHC Crawfordsville

1702 Lafayette Rd.

Crawfordsville, In 47933

Phone: 765-362-5100

Fax: 765-362-5171

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