Valley Professionals Community Health Center

VPCHC Rockville

727 North Lincoln Rd

Rockville, In 47872

Phone: 765-569-1123   Fax: 765-569-6412

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