Valley Professionals Community Health Center

VPCHC South Terre Haute
4757 South 7th St.
Terre Haute, In 47802

Phone: 812-234-2289 Fax: 888-815-1058

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