Valley Perinatal™

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section I: Patient Information

Patient Name (Last, First, Middle Initial):		
Date of Birth:	Social Security Number:	Medical Record Number:
Address:		

Section II: Provider of Medical Information

Name:	Phone:
Organization:	
Address:	

Section III: Information Requested

Records to be Released:

□	History and Physical Evaluation	□	Laboratory Reports	□	Operative Report
□	Discharge Summary	□	EKG Reports	□	Pathology Report
□	X-Ray Reports/Ultrasound Reports	□	Other(Specify)_____		

Dates of Treatment:

Purpose of Disclosure:

Section IV: Recipient of Information

Name:	Phone:
Organization:	
Address:	

I AUTHORIZE THE RELEASE OF RECORDS, INCLUDING THOSE WHICH MAY CONTAIN CONFIDENTIAL HIV/AIDS RELATED INFORMATION, (INCLUDING TESTING, DIAGNOSIS OR TREATMENT), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, INFORMATION RELATING TO MENTAL HEALTH and/or ALCOHOL/DRUG USE, AND THE CARE AND TREATMENT THEREOF.

Pursuant to the HIPAA Privacy Rules, the patient or his/her authorized representative acknowledges that he/she:

1. Has the right to revoke this authorization in writing to the extent that a covered entity has not already relied upon the patient's consent to use or disclose protected health information. This authorization shall remain in force until it is revoked □ (check box) or _____ (list date), whichever occurs first.
2. Understands that the health information used or disclosed following this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rules

_____ Print Name of Patient

_____ Print Name of Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date Signed