ValleyHealth
Valley Physician Enterprise

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ SS #: _____

_____ MR#/Acct # _____

I hereby authorize *(hospital/program)* _____ to release to

(complete name and address, phone/fax) _____

the following:

Extent or nature of use/disclosure covering the period(s) of health care: *(check or list all that apply)*

Time frame from _____ to _____

from _____ to _____

- ☐ Abstract (*H&P, Consult, DS, OP Notes, All Testing*)
- ☐ Entire Record
- ☐ ER Record
- ☐ EKG's
- ☐ Laboratory Results
- ☐ Other *(specify)* _____
- ☐ X-Ray and Imaging Reports
- ☐ Psych Testing
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Physician orders
- ☐ Discharge Summary

I understand that the information in my health record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

The disclosed information is to be used by the following individual organization for the purpose of:

☐ Continued Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other *(specify)* _____

This authorization will expire in one year, unless otherwise indicated below:

- ☐ Six months
- ☐ On (*specify date or event*) _____

I understand this consent is voluntary and that I have a right to revoke this authorization at any time, except to the extent that action based on this consent has already been taken. I understand that if I revoke this authorization I must do so by written, dated, and signed communication to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact VALLEY ORTHOPEDIC TRAUMA SPECIALISTS

_____ _____

Signature of Patient or Legal Representative Date signed

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

_____

Reason for patient's inability to sign

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been ☐ accepted ☐ rejected by the patient/representative.

Form 6581
Rev 06/04, 10/04

Patient Label