ValleyHealth
Healthier, together.

Thank you for contacting Valley Health System for all your healthcare needs. You have the right to inspect and obtain a copy of your medical and billing records that we maintain. If you request copies of your records, we will notify you of any charges associated.

Additional ways to request information are available on our Valley Health website. These available avenues include My Chart and the Medical Records Department. If you are requesting information that cannot be fulfilled by the above avenues please complete the form below and return to ishelpdesk@valleyhealthlink.com.

Once you send this additional information, a team consisting of HIM, Compliance and Security will review your request and route it to the appropriate support team.

Patient Information: (Individual whose information will be released)

First Name_____

Middle Name_____

Last Name_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Maiden Name if applicable:_____

Date of Birth: _____ (Format mm/dd/yyyy)

Email Address_____

Direct Line_____ (Only numbers, no dashes or parentheses)

Cell Phone Number _____ (Only numbers, no dashes or parentheses)

Do you have an established relationship with Valley Health Yes☐No☐

Description of the information are you requesting? Please provide as much detail as possible.

Time frame of requested records From: _____ To: _____ (mm/dd/yyyy)

How are you requesting to receive this information? Check all that apply.

- ☐ CD
- ☐ USB Drive
- ☐ App or API (Mobile Integration)
- ☐ Portal Request of Data to a 3rd party application
- ☐ Paper records
- ☐ Secure message (will require a login)
- ☐ Unencrypted email
- ☐ Other preferred form and format:

***If you are requesting this information via email please note that this is unencrypted and that there is risk that the information may be viewed by unauthorized persons while transmitted. By signing below you agree that you accept this risk.*

***If you are requesting this information via an API, Valley Health is not responsible or liable if this app does not have the appropriate privacy and security in place. We do encourage you however to review the privacy policy of the app prior to downloading to your device. It is also strongly recommended that you password protect your mobile device if you are intending to store medical information on it.*

What format are you requesting this information in? Check all that apply

- ☐ PDF
- ☐ JPEG
- ☐ TIF
- ☐ CCDA
- ☐ Electronically Transported (If so how?) _____

Print Name:_____

Relationship (if authorized representative of patient):_____

Signature:

_____

Date: _____(MM/DD/YYYY)

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g., Health Care Power of Attorney).