067272

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Valley Health Family Medicine/Inwood
4803 Gerrardstown Rd.
Inwood, WV 25428
P 304-821-9011
F 304-821-9012

ValleyHealth
Healthier, together.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ SS # (last 4) _____

_____

Phone #: _____ Fax #: _____

Email address: _____ MR#/Acct # _____

I hereby authorize *(hospital/program)* _____ to release to/obtain from *(circle one)*

(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*)
- ☐ Discharge Summary
- ☐ EKG's
- ☒ Entire record
- ☐ ER Record
- ☐ Face Sheet
- ☐ Implant Record
- ☐ Laboratory Results
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Radiology/Imaging Reports ☐ CD
- ☐ Other (specify): _____

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).

Please provide records in the following format (*please check appropriate box*): ☒ Paper ☐ CD ☐ MyChart ☒ Fax
☐ Secure email ☐ Unsecure email (Risk of interception by outside party is acknowledged by requester)

The disclosed information is to be used by the following individual organization for the purpose of:
☒ Continued Care ☐ Insurance ☐ Legal ☐ Military ☐ Personal Use Other *(specify)*_____

This authorization will expire in one year, unless indicated ☐ 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 the Health Information Management Department at (540) 536-8080.

_____ _____

Signature of Patient or Legal Representative Date/Time signed

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness (Include Date/Time)

_____

Reason for patient's inability to sign

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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.

Patient Label