Berkeley Family Medicine

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Authorization to Disclose Protected Health Information

You are entitled under HIPAA Privacy Law to access your personal protected health information. If releasing protected health information, Berkeley Family Medicine will release only records produced by Berkeley Family Medicine. If requesting protected health information, Valley HealthBerkeley Family Medicine will assist you in obtaining records from healthcare providers outside the Network.

I, ____, date of birth, __________________, authorize the disclosure of my personal protected health information as follows:

From:

____
Name or Business

____
Address

____
City, State and Zip Code

____
Phone and Fax Number

To:

____
Name or Business

____
Address

____
City, State and Zip Code

____
Phone and Fax Number

☐ Patient/Guardian or specified entity/individual will pick up the information
☐ Please forward the information to the specified address and/or fax number

Specific Information to be disclosed — please select which items you are requesting	
☐ Demographics	☐ Behavioral Health Visits
☐ Diagnosis/Problem List	☐ Labs
☐ Medication List	☐ Reports/Tests
☐ Immunization Records	☐ Billing Records
☐ Encounters	☐ Other

Dates of Service Requested ______________________ to ______________________
(unless otherwise noted, the last office visit will be provided).

This authorization will expire one yearf rom the date ofs ignature. This authorization may be revoked by me or my designee at any time except to the extent that the person/organization making the disclosure has already acted. I understand that there may be a charge for the requested information. Re-disclosure oft his information to a party other than the one designated above is forbidden without written authorization; I understand that this information may be subject to re-disclosure by the recipient and may no longer by protected by Federal or State Law.

____ ___________________________
Patient and/or Legal Representative Signature Date