Uniquely connected. For life.℠
HERITAGE VALLEY
Health System

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please print clearly)

PATIENT INFORMATION:

Name: First_____Middle_____Last_____

Social security number_____Date of birth_____

I THE UNDERSIGNED, HEREBY AUTHORIZE: (facility that has records)

Facility name: _____Phone_____

Address: Street_____City_____State_____Zip_____

TO PROVIDE: (facility where records are to be sent)

Facility name: _____

Address: Street_____City_____State_____Zip_____

WITH THE FOLLOWING INFORMATION:

- ☐ Progress notes
- ☐ Drug\medication Record
- ☐ EKG report
- ☐ Lab results
- ☐ Consultation
- ☐ Accounting of disclosures
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Cardiac Cath Report
- ☐ Pathology Report
- ☐ Special Procedure
- ☐ Operative Report
- ☐ Pulmonary Function
- ☐ Entire Record
- ☐ Other_____

From the following dates of service/treatment: From:_____ To:_____

Purpose of Disclosure:_____

☐ **Check here to indicate that future healthcare services will not be sought at this location.**

Expressed Authorization: ******Signature Required******

I understand that my medical record may contain information related to:

- ***Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV***
- ***Psychiatric Care***
- ***Treatment for alcohol and/or drug abuse.***

I give my consent for release of this information: _____
Signature Date

~or ~

I DO NOT give consent for release of this information: _____
Signature Date

Paper copies (Note that there will be a **charge** for the cost associated with copying your records. You will be informed of, and billed for, these charges prior to the release of the copies)

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information.

⇨_____
Required: Signature of Patient Date

_____
***Signature if other than patient** Relationship Date

_____
Signature of witness Date

*** For signature other than patient, please attach P.O.A. documentation**

☐ Patient given a copy of consent form Records sent: _____By: _____
Date Employee signature

Patient signature required on back of form.