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HERITAGE VALLEY
Health System

Valley Internal Medicine - Center
Dr. William Rust/Dr. Matthew Sniezek
79 Wagner Road, Suite 204
Monaca, PA 15061-3028

AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name (print): _____

Patients Social Security Number: _____ D.O.B. _____
To the following individuals.

Phone #

Name Of Person or Facility _____ Relationship to Patient _____
Phone #

Name Of Person or Facility _____ Relationship to Patient _____
Phone #

Name Of Person or Facility _____ Relationship to Patient _____
Phone #

Name Of Person or Facility _____ Relationship to Patient _____
Phone #

Name Of Person or Facility _____ Relationship to Patient _____

I give permission for information Re: my test results to be left on my answering machine. ☐ Yes ☐ No
The information in my Medical Record may be released to the above individuals either by telephone or in consultation by any of the providers in our office.

HIV, Behavioral Health and Drug & Alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: _____ HIV _____ Behavioral Health _____ Drug & Alcohol

I understand that this authorization will stay in effect until revoked by me in writing.

GENERAL AUTHORIZATION

Patient Signature _____ Date _____