FAX TO: 855-396-3837



Phone Number: Phone Number: Phone Number: Phone Number:	Patient Name:				
Doctor / Clinic / Other: Phone:	Other Name(s) Used/ Maiden Name	:			
Phone:	REQUI	EST COPY OF MY PRIVATE HEALT	HINFORMATION FROM	<u>l:</u>	
Address: City: State: Zip:	Doctor / Clinic / Other:				
am requesting records for the following timeframe (Please select one):All records, ORSpecific Date(s): to					
Specific Date(s):	Address:	City:	State:	Zip:	
Clinic Notes/ Records	am requesting records for the following			to	
Immunization Records	=				
RELEASE MY PROTECTED HEALTH INFORMATION TO: [Two options below, Please ONLY check one) need this for: [] Myself [] Doctor/ Clinic/ Other					
RELEASE MY PROTECTED HEALTH INFORMATION TO: [Two options below, Please ONLY check one) I need this for: [] Myself [] Doctor/ Clinic/ Other					
need this for: [] Myself [] Doctor/ Clinic/ Other	Mental Health Treatment	Drug & Alconol Treat	mentOther		
need this for: [] Myself [] Doctor/ Clinic/ Other					
hone: Fax: State: Zip: State: Address: City: State:					
Phone:	RELEASE MY PROTEC	TED HEALTH INFORMATION TO :	[Two options below, Please	e ONLY check one)	
Phone: Fax:	need this for: [] Myself				
Address:		er			
Address:					
would like my records to be sent by: (please initial) Hard copy Encrypted Email: encrypted email will require the recipient to use a code sent to their ema address to open the original encrypted email. FAX to another provider Unencrypted Email: By selecting unencrypted Email, Patient/Authorized Representative ag to assume any risk that the email may be intercepted during its transmission to the other poly signing this form, I understand that: 1. Only records contained in Greater Valley Health Center electronic health record will be sent. 2. All sections must be completed and signed prior to processing. 3. Treatment, payment enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. 4. Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law. 5. I have the right to change my mind at any time. If I cancel this release it must be done in writing. I understand some records may have already been sent before I cancel. Imay see a copy of this form as per law (45 CRF 164.524). I understand that once my notes are sent to someone else, the information may not be protected by state or Federal confidentiality rules. If I have questions about who can see my health information, I can contact Greater Valley Healt Center's Medical Records Staff at 406-607-4900. This authorization will expire 6 months from the date of signature below.					
would like my records to be sent by: (please initial) Hard copy					
Hard copy Encrypted Email: encrypted email will require the recipient to use a code sent to their ema address to open the original encrypted email. PAX to another provider Unencrypted Email: By selecting unencrypted Email, Patient/Authorized Representative ag to assume any risk that the email may be intercepted during its transmission to the other public signing this form, I understand that: 1. Only records contained in Greater Valley Health Center electronic health record will be sent. 2. All sections must be completed and signed prior to processing. 3. Treatment, payment enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. 4. Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law. 5. I have the right to change my mind at any time. If I cancel this release it must be done in writing. I understand some records may have already been sent before I cancel. I may see a copy of this form as per law (45 CRF 164.524). I understand that once my notes are sent to someone else, the information may not b protected by state or Federal confidentiality rules. If I have questions about who can see my health information, I can contact Greater Valley Health Center's Medical Records Staff at 406-607-4900. This authorization will expire 6 months from the date of signature below. Patient/ Authorized Representative	-				
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PRINT: SIGNATURE: Date:	•				
	PRINT:	SIGNATURE:		Date:	
	Witness SIGNATURE:		Expirat	ion Date:	