FAX TO: 855-396-3837

GREATER VALLEY HEALTH CENTER

Patient Name: _____ Date of Birth: _____

Other Name(s) Used/ Maiden Name: _____ Phone Number: _____

REQUEST COPY OF MY PRIVATE HEALTH INFORMATION FROM:

Doctor / Clinic / Other: _____

Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

I am requesting records for the following timeframe (Please select one): ____ All records, OR
____ Specific Date(s): _____ to _____

I need the following records to be sent to GVHC (Please initial those that apply):

_____Clinic Notes/ Records	_____ Pathology Records	_____ Imaging Results
_____ Immunization Records	_____ Lab Records	_____ AIDS/HIV Related Information
_____ Mental Health Treatment	_____ Drug & Alcohol Treatment	_____ Other _____

RELEASE MY PROTECTED HEALTH INFORMATION TO: [Two options below, Please ONLY check one)

I need this for: [ ] Myself
[ ] Doctor/ Clinic/ Other_____

Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

I 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 email address to open the original encrypted email.

_____ FAX to another provider

_____ Unencrypted Email: By selecting unencrypted Email, Patient/Authorized Representative agrees to assume any risk that the email may be intercepted during its transmission to the other party.

By 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 be 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

PRINT: _____ SIGNATURE: _____ Date: _____

Witness SIGNATURE: _____ Expiration Date: _____

Revision date: 7/21/23