Authorization To Release Protected Health Information

GREATER VALLEY HEALTH CENTER

Patient Information

Legal Name: _____ Date of Birth: _____
Phone: _____

Clinic / Health Care Provider Releasing Information
(Who has the information you want to be released?)

Facility Name: _____ City: _____ Phone: _____

Facility Name: _____ City: _____ Phone: _____

Facility Name: _____ City: _____ Phone: _____

Receiving Party
(Who do you want your protected health information to be released to? (Myself, Doctor Office, Clinic, other.)

Facility Name: _____ Phone: _____ Fax: _____

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

Information To Be Released
(What records do you want to release? Check the appropriate box(es).

I am requesting records for the following timeframe**. Specific Dates: _____ to _____.**

If no dates are listed above, we will send one year of records.

I need the following records *(check the box(es) for those that apply):*

☐ Clinic Notes/ Records	☐ Substance Use Disorder Treatment (***If you want to release SUD related information, please ask for the SUD Treatment ROI)***
☐ Immunization Records	☐ Pathology Records
☐ Lab Records/Imaging	☐ Mental Health Treatment
☐ AIDS/HIV Related Information	☐ Other _____

Release Instructions
(How do you want your records released?).

I would like my records to be sent by: **(check the applicable box below:)**

☐ **Encrypted Email**: encrypted email will require the recipient to use a code sent to their email address to open the original encrypted email. **EMAIL**: _____

☐ **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.
EMAIL: _____

☐ FAX to another provider ☐ Hard Copy

Purpose of Release
(Why are records being requested)

☐ Patient Request ☐ Other _____

Release Acknowledgement

By signing this form, I understand that:

Only records contained within Greater Valley Health Center's electronic health record (EHR) will be released.
All sections of this authorization must be completed and signed prior to processing.
Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.
I have the right to revoke this authorization at any time by submitting a written request. I understand that some records may have already been released prior to my revocation.
I understand that substance use disorder (SUD) treatment information is protected under federal regulations **42 C.F.R. Part 2** and **HIPAA 45 C.F.R. § 164.508.** These records cannot be further disclosed by the recipient unless expressly permitted by these regulations.
I may review or obtain a copy of this form in accordance with **45 C.F.R. § 164.524.**
I understand that once my information has been disclosed, it may no longer be protected by State or Federal confidentiality rules.
If I have questions about who may access my health information, I may contact Greater Valley Health Center's Medical Records Staff at (406) 607-4900.

This authorization will **expire six (6) months** from the date of signature below, unless otherwise specified.

Authorization & Signature

Signature of Patient/Legal Representative _____ Date: _____

Relationship to Patient: _____ Witness Signature: _____ Printed Name: _____

Revocation Authorization

I hereby revoke (cancel) this Authorization to Disclose. Cancellation

Signature: _____ Date: _____