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

OR

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

I need this for: [ ] Myself ($0.25/printed page or $2.00/Compact Disc)
[ ] 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 _____

Initial the records you are requesting GVHC release.

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

By signing this form, I understand that:

1. Only records contained in Greater Valley Health Center electronic health record will be sent.
2. Form must be complete and signed prior to processing.
3. 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.
4. I choose to sign this form. I can also refuse to sign this form. I need not sign this form to receive care, payment for services, or get insurance help.

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. This authorization will expire 6 months from the date of signature below.

Patient/ Authorized Representative SIGNATURE: _____ Date: _____

Witness SIGNATURE: _____ Expiration Date: _____

Revision Date: 8.26.2021