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 _____

OR

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: _____

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	_____ AIDS/HIV Related Information
_____ My visit Schedule	_____ Billing Information	_____ Other _____
_____ Mental Health Treatment	_____ Drug & Alcohol Treatment	

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. 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.
6. 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 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: 5/10/22