Authorization for Release of Protected Health Information/PVMC

Name: ____ **Date of Birth:** ___________________

Address: ____ **SSN:** __________________________

____ **Telephone:** ______________________

Information Is To Be Release By:

____

Physician or Facility

____

Street Address

____

City, State & Zip

____

Telephone Number

Information Is To Be Sent To:

____

Physician or Facility

____

Street Address

____

City, State & Zip

____

Telephone Number

Information to Be Released – Covering the Periods of Health Care

From (Date): ____________________________________ **To (Date):** ______________________________

Please check type of information to be released:

Complete Health Records | Pathology Report | Radiology Report

Laboratory Test Results | Complete Billing Record | EKG Report

Other (Specify): ____

Purpose of Request:

Treatment or Consultation | At Request of Patient | Billing or Claims Payment

Other (Specify): ____

Drug and/or Right to Revoke Authorization:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse. Psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One: YES NO**

I understand if my medical or billing records contains information in reference to HIV/AIDS testing and/or treatment I agree to its release.
Check One: YES NO

Time Limit & Right To Revoke Authorization:

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to PVMC to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _________________________________, or 90 days from the date of signature, unless otherwise specified.

Re-release:

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the health Insurance Portability and Accountability Act of 1998. The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal representative Who May Request Disclosure:

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider; identified above, to release you protected health information specified above.

Signature: ____ Date: ____________________________

Authority to Sign – if not patient: _______________________________________ Witness: _________________________

ID Verified by: ____

**** Please do NOT fax records over 50 pages. This practice prefers mail paper copies or CDs. Thank You!**