Phone: 907-586-2434
Fax: 907-586-2446
medicalrecords@valleymedicalcare.com

Authorization for Release of Medical Information

Patient Name ____ Date of Birth _______________

Phone Number______________________________ Relation to Patient __________________________

Information to be released **FROM**:	Information to be released **TO**:
Valley Medical Care ☐ Other ☐	Valley Medical Care ☐ Other ☐ Self ☐
Facility Name & Address: _________________	Facility Name & Address: _________________
______________________________________	______________________________________
______________________________________	______________________________________
Fax: _____________ Phone:_______________	Fax: _____________ Phone:_______________
Email _________________________________	Email _________________________________

Type of Information: X-Ray Results ☐ Lab Results ☐ Office Notes ☐ Complete Chart* ☐

If you ask for your complete chart to be sent, the office will default to releasing the last two years of records* ***unless date range indicates a different span of time**

Additional Details: ____

____

Records to be Released: From: _________________ To: _________________ (MM/DD/YYYY)

Method of Delivery, if Released to Patient: Faxed ☐ Emailed ☐ Mailed ☐ Picked Up ☐

Patient Acknowledgment:

I understand information in my record *may* include sexually transmitted diseases acquired immunodeficiency syndrome (AIDS) or related diseases, or may include information about behavioral or mental health services or treatment for alcohol and/or drug abuse. *Please initial here if you do not want this information release.* **INITIAL** ________

I understand that any disclosure of information carries with it the potential for disclosure by the recipient and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information released prior to this revocation. I understand authorizing disclosure of this health information is voluntary. I understand I am, not required to sign this authorization to receive treatment. I understand that if this information is require for participation in a research study, my enrollment may be denied if I do not sign the authorization.

I understand that I may inspect or request a personal copy of the information to be disclosed.

*****Please allow up to 30 business days for processing*****

Responsible Signature ____ Date ________________

Please note: Authorization valid for **90 days only** and may be revoked in writing at any time prior to 90 days by notifying the Medical Records Department. **We cannot complete your request without complete information.**