VMA

Valley Medical Associates
Adult & Pediatric Medicine

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MEDICAL RECORDS RELEASE FORM

_____ _____ _____

Patient Name Patient DOB Patient Phone #

Release of Information

I authorize the release of my health information from VALLEY MEDICAL ASSOCIATES to:

Recipient: _____

Address: _____

What to release: This authorization permits VMA to disclose the following health information about me **(specifically describe the information to be disclosed or indicate ALL RECORDS.)**

_____

_____

Purpose of Request _____Leaving the practice _____ Legal _____Personal _____Other_____

Requests from Another Person or Provider:
I hereby authorize VMA to obtain my protected health information from:

_____

Release of Privileged Information: My health information may contain information about drug abuse, alcoholism, alcohol abuse, sexually transmitted disease, abortion, hepatitis C or mental health treatment.
CHECK ONE: ____ I AM _____ IAM NOT willing to have this information disclosed.

Release of HIV/AIDS Information: My health information may contain information relating to AIDS OR HIV testing.
CHECK ONE: ____ I AM _____ I AM NOT willing to have this information disclosed.
*Signature*_____ *Date*_____
(signature only for release of HIV information)

***Individual Rights*:** I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of VMA Medical Records
- My right to revoke does not apply to information that has already been released on the basis of this authorization.
- There may be a charge for providing copies of medical records.

Patient Signature: _____ **Date:** _____

Legal Representative: _____ **Date:** _____

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