Authorization for Use/Disclosure of Protected Health Information (PHI)

Risk & Compliance
RC.204.004

Patient: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone number(s): Cell # _____ Home # _____ Work # _____

Other names under which patient has been treated: _____

Release Information From: The following entity/individual is authorized to disclose my PHI:	**Release Information To:** The following entity/individual is authorized to access, use, and receive my PHI:
☐ Valor Health 1202 E. Locust St. Emmett, Idaho 83617 Phone: (208) 365-3561 Fax: (208) 365-1575	☐ Valor Health 1202 E. Locust St. Emmett, Idaho 83617 Phone: (208) 365-3561 Fax: (208) 365-1575
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____ Office Use Only MRN#_____ ❑ Mailed ❑ Fax ❑ In person ❑ Worker's Comp ❑ ID checked /Initials

Purpose of Use and Disclosure:

☐ Insurance ☐ Legal ☐ Personal ☐ Treatment/Continued Care ☐ Worker's Compensation ☐ School
☐ Occupational Services ☐ Employee Wellness ☐ Other_____

This request is valid for services for the following dates: *(Select one of the following options.)*

☐ Approximate service date(s) _____.
☐ All visits between the dates _____ and _____. ☐ *or the expiration of this form.*

Information to be Used or Disclosed:

☐ Billing Information	☐ Mental Health Evaluation/Studies	☐ Imaging Film/Reports	☐ Psychotherapy Notes*
☐ Discharge Summary	☐ Clinic/Progress Notes	☐ Immunizations and/or Titers	☐ Drug and/or Alcohol Results
☐ Emergency Room Record	☐ Medical Clearance	☐ Lab/Pathology	☐ Consultation Reports
☐ Operative/Procedure Report	☐ Employment/DOT Physical Screening	☐ History/Physical	☐ Breast Imaging w/report
		☐Other _____	

Choose one format for receiving the information: ☐Paper ☐Fax ☐Electronic copy ☐Other_____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.
*__Please note that psychotherapy notes require a separate authorization__.

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. __To revoke this authorization__, **I must submit a written revocation to Health Information Management (Medical Records). If I do not, this authorization will expire one (1) year from date signed.**

I understand that Valor Health may not condition the Patient's healthcare on this authorization unless (1) the purpose for Valor Health's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Valor Health pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

I understand that if I choose to receive or have Valor Health send my PHI through electronic mail (email), that email is considered unsecure and I hereby release Valor Health from any and all responsibility and/or liability regarding the sending of PHI in this format.

Signature of Patient/Parent/Representative Date Time

If Representative, reason patient is unable to sign: _____

Representative's relationship to patient: _____

Signature of Witness Date Time

Interpreter: (print name if used)