VALLEY HEALTH CLINIC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize ___Valley Health Clinic____ to use and/or disclose
Practice Name
certain protected health information (PHI) about me to _____. This
Name of entity to receive this information
authorization permits _____Valley Health Clinic___ to use and/or disclose the
Practice Name
following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____.

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from _____. In
Practice Name
fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this

authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

_____
Address

_____ _____ _____
City State Zip Code

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION