VALKO & ASSOCIATES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (2019)

9:11-A

PATIENT INFORMATION

Last Name:	First Name:	M.I.	Date of Birth:

Street Address:	City:	State:	Zip:	S.S.N#

I HEREBY AUTHORIZE THE DISCLOSURE OF HEALTH INFORMATION ABOUT THE INDIVIDUAL ABOVE:

Last Name:	First Name:	Phone#

Street Address:	City:	State:	Zip:

Relationship to Patient: ☐Self ☐Parent ☐Legal Representative ☐Spouse ☐Other _____

HEALTH INFORMATION TO BE RELEASED / DISCLOSED

☐ Diagnostic Assessment ☐ Treatment Plan ☐ Testing Result ☐ Diagnosis ☐ Laboratory Reports

☐ Last 5 Notes of Service ☐ Billing Statements ☐ Discharge Summary ☐ Psychotherapy Notes

☐ Entire Record, Except Psychotherapy Notes ☐ Other: _____

Specify Time Period, If Desired: **Release Only Information From The Period of:**	mm/dd/yyyy	to	mm/dd/yyyy

REASON FOR DISCLOSURE

☐ Continuation of Care ☐ Attorney ☐ Personal Use ☐ Substantiation of Payment Claims

☐ Other: _____

RECIPIENT OF INFORMATION

Entity or Individual:	Relationship:

Street Address:	Phone#

City:	State:	Zip:	Fax#

AUTHORIZATION TO REMAIN ACTIVE UNTIL REVOKED or SHALL EXPIRE ON DATE SPECIFIED

• I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to consent a claim under my policy.

Expiration Date or Event:	•• If not date or event has been specified, in accordance with State law, unless otherwise revoked, this authorization will expire in (1) year.

• I understand that this authorization is voluntary and that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.

• I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

• I understand that information disclosed by this authorization, except as prohibited by CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule (45 CFR Part 164)

Signature of Invividual or Authorized Representative	Date:

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