VALLEYCARE HEALTH SYSTEM

Health Information Management Department
1111 E. Stanley Boulevard, Livermore CA 94550
Telephone: 925-373-8019 Facsimile: 925-373-4126 Attn: Jennifer Garcia

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

* Requestor's Phone Number: _____

* Social Security Number of patient: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide **all** information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

* I, _____
Last name First name Middle initial

(Address)

_____
Street City State Zip code

hereby authorize **ValleyCare Health System** to disclose the following information:

* a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received **– OR -**
☐ Only the following records or types of health information (including any dates):

_____

* b. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information

☐ HIV test results

☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

RELEASE MEDICAL INFORMATION/RECORDS TO:

***** Name: _____

* Address: _____

PURPOSE

* Purpose of requested use or disclosure: ☐ Patient Request

_____

Patient Last name First name Middle initial Date of Birth

☐ Other: _____

Dates of service to be released: _____

EXPIRATION

* This Authorization expires (insert date or event): _____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits but will prevent the release of medical information and records.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: ValleyCare Heath System, HIM Department, 1111 E. Stanley Blvd., Livermore, CA 94550.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

* Date: _____ * Time: _____AM/PM

* Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____. Witness: _____