



AUTHORIZATION TO RELEASE INFORMATION

Date of Service: _____		Time: _____		Loc: _____	
Patient Name: _____			Chart # _____		
Address: _____			City: _____		
Home: () _____		Emg: () _____			
DOB: __/__/__		Sex: ____		Age: ____ Act# _____	
Ins. Plan: _____					
(PLACE LABEL HERE)					

SECTION 1

I understand that signing or choosing not to sign this form will in no way affect the quality of care I receive at Northeast Valley Health Corporation. I authorize Northeast Valley Health Corporation to release, receive and share the following information for the purpose(s) of diagnosis, treatment and referral by initialing each of the appropriate lines below:

_____ Entire Medical Record Initial _____ _____ Hospital Discharge Summary (CCD) Initial _____ _____ Other: _____ Initial _____ Please Specify _____	_____ HIV Test Result(s) Initial _____ _____ Substance Use/Abuse History Initial _____ _____ Mental Health Information Initial _____
---	---

Authorization is hereby given to:

To Release Information To:

Agency Name: _____ Address: _____ City, State, Zip Code _____ Phone Number: _____ Fax Number: _____	Agency Name: _____ Address: _____ City, State, Zip Code _____ Phone Number: _____ Fax Number: _____
--	--

This authorization is valid for one year from the date it is signed and may be revoked at any time by verbally informing an employee of NEVHC and/or signing the revocation line below. I understand that I may request a copy of this form for my personal records. I understand that information used or disclosed with this authorization may be subject to disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

Patient/Parent/Guardian Signature: _____	_____/_____/_____ Date Signed (mm,dd,yy)
Witness Signature: _____	_____/_____/_____ Date Signed (mm,dd,yy)

SECTION 2

Revocation/Cancellation of Release

Print Name: _____

Patient/Parent/Guardian Signature: _____

_____/_____/_____
Date Signed (mm,dd,yy)

If cancellation is made via telephone, please note on signature line and print name

Original to Med Record; Copy to Agency; Photocopy provided to Patient/Client upon request