6801 Coldwater Canyon Avenue ▪ North Hollywood, California 91605 ▪ (818) 763-8836 ▪ Fax (818) 301-6385

Valley Community Healthcare

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

(Note: Due to volume of requests the turn-around time for Medical Records is an estimated 8-10 business days from date of request for the years of 2014-present. Any request for the years before 2013 will be up to 10-15 business days.)

Section A: Patient Information

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____

Section B: Medical Center Information

I request and authorize _____ to release healthcare information of the patient named above to:

Please send my health information to:

☐ **Valley Community Healthcare** ☐ **Email Records to: mr@vchcare.org** ☐ **Patient pick up** ☐ **To Be Mailed to:**

Name: _____ Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

Fax Number: _____

Section C: DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

☐ Complete Medical Record- Patient is transferring facilities **(Medical Records will be sent to new medical center)**

☐ Complete Medical Record for personal use - $15.00 service fee **(Please specify content and dates of service)**:

_____

☐ Other - $15.00 service fee **(Please specify content and dates of service)**:

_____

☐ You must check this box if you are also requesting Billing Records

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 est. seq., includes herpes, herpes simplex, human papilloma virus, wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDs testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

DISCLAIMER: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature. This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained by me or unless disclosure is specifically required or permitted by law.

Signature of Patient: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

(IF WITNESS SIGNATURE IS NOT PROVIDED, REQUEST WILL NOT BE PROCESSED)