Valley Health Plan®

VHP Authorization for Use and/or Disclosure of Protected Health Information

AUTHORIZATION: I give permission to _____
Name of Person/Organization Allowed to Release Records

to use and release to _____
Name of Person/Organization Allowed to Receive the Records

_____
Address City State Zip

for the record and information as identified below related to:

_____
Last Name First Name Middle Initial

_____
VHP ID Number Date of Birth Telephone Number

RECORDS: *Important:* Check the appropriate box or boxes and initial, sign and data as required.

1. ☐ **MEDICAL RECORDS** - Initials: _____
References to the following types of information may be in or part of your Medical Records and if you want any of these types of information to be released with your Medical Records, you must sign and date next to each type.

☐ Drug/Alcohol Treatment Information - Sign & Date _____

☐ Testing Information - Sign & Date _____

☐ Reference to or Results of HIV Blood Test Information - Sign & Date _____

2. ☐ **BEHAVIORAL HEALTH RECORDS** - Sign & Date _____

3. ☐ **OTHER** (***Please be specific***) _____
Sign & Date _____

LIMITATION ON RELEASE: The following is a specific description, limitation of the records(s) checked above and dates(s) of the service. If there are not limitations, please write *No Limitation.*

_____

_____

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USES: The person who receives the health information can use it only for the following reason(s):

_____

I understand that the person who receives the information cannot use the information for anything else or disclose the information to anyone unless I give them a written authorization or the law allows it.

DURATION: This authorization is valid immediately and will be valid until _____*(provide date).* If I do not write in a date, it will expire six (6) months from the date it was signed.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization if I ask for it. Copy requested and received: Yes ☐ No ☐ _____
(Initial)

CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation must be (1) in writing, (2) sent or given to the entity that you submitted the authorization form to, and (3) is effective when it is received. A cancellation will not apply to actions already taken by that entity under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim.

CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.

SIGNATURE: _____
If signed by other than patient, state relationship and authority to sign.

_____

Relationship to Patient Authority to Sign

_____

Signature of Witness Print Witness Name Date

FOR BEHAVIORAL HEALTH USE ONLY

Complete the following if the patient is the person authorizing release of his/her records subject to California Welfare and Institutions Code Section 5328: The Undersigned (the physician, licensed psychologist, or social worker with A Master's degree in social work) who is in charge of the patient, hereby (approves) (disapproves) the release of information and records to Requestor. If disclosure is disapproved, give reasons below. Also note below or attach any restrictions on the release of records. (No approval is required for release to a patient's attorney.) _____

_____

_____ _____ _____

Date Physician/Psychologist/Social Worker Degree