Valley Care Clinics
The care you need, when you need it

Authorization Release for Medical Records

I authorize: _____
(Name, Address, Phone, and Fax)

To release to: Valley Care Clinic,

The health records diagnosis, treatment and related information of:

Name: _____

Social Security #: _____ DOB: _____

Covering the dates of service from _____ to _____

Medical information to be disclosed, photocopied or faxed includes those checked:

Entire Record: ___ Laboratory & Radiology Results: ___ Operative Report: __

History & Physical: __ EKG/Diagnostic Reports: __ Discharge Summary: __

Consultations: __ All Dictations/Progress Notes: __

Other:_____

If my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42 CRF parts 2, the records cannot be closed without my written consent unless otherwise provided for the regulations. A general authorization for medical records is not sufficient for this purpose. Federal rules restrict any of us the information to criminally investigate or prosecute any alcohol or drug abuse patient. With respect to any mental health information, which may be contained in the medical records, I hereby waived my/his/her right to the privileges of confidentiality.

I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't affect any actions taken before they received the notice.

_____ _____

Signature of Patient **Date**