QUINCY VALLEY
MEDICAL CENTER

Verification of identity/Authority Attached
Identification Required for Authentication:
Driver's license, photo ID, power of attorney, warrant, subpoena or other legal process.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Authorization VOID if not completely filled out)

PATIENT INFORMATION:

Printed Name of Patient ______________________ Previous Names, If Applicable ______________________

Address ______________________ E-mail: ______________________

Date of Birth ______________________ Phone Number ______________________

SEND INFORMATION TO: (Be Specific)

Provider Name/Organization ______________________ Name of Receiving Person ______________________

Address ______________________

Phone Number ______________________ Fax Number ______________________

INFORMATION TO BE RELEASED FROM: (Be Specific)

Provider Name/Organization ______________________

Address ______________________

Phone Number ______________________ Fax Number ______________________

Purpose of Disclosure: Transfer of Care Self Specialist Other: ______________________

INFORMATION TO BE DISCLOSED:

Medical Records from Last 2 Years
Complete Designated Record Set
Summary Health Information
Other: ______________________

Date of Service ______________________ Expiration Date (or event) ______________________

SENSITIVE INFORMATION:

This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you DO NOT want this released.

Mental Health/Psychiatric Disorders
Drug, Alcohol Abuse/Treatment
Reproductive care (minors only)
HIV/AIDS Virus
Sexually Transmitted Diseases
Other: ______________________

- If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.
- This form will be active for 90 days upon receipt or 30 days for special consents below and may be revoked at any time on form 3(c), Authorization Revocation, proving the information has not already been disclosed. Upon receipt of this authorization, Quincy Valley Family Clinic has 15 days to comply with your request and will charge reasonable cost-based fee for each disclosure within a given year.
- We will not condition treatment on the completion of the authorization. Please be aware that once we disclose this information per your instructions the information is subject tore-disclosure.

______________________ ______________________ ______________________
Date **Signature of Patient or Representative** **Relationship to Patient**

PLEASE NOTE: For patients requesting copies of personal or dependent records, the first 25 pages will be provided at no cost; additional pages will be subject to costs reflected below:

26 to 55 pages: $1.17 per page
56 pages or more: $0.88 per page

If your request is over 25 pages our Medical Records department will send an invoice to the e-mail specified under 'Patient Information' above.You can pay in person at our facility or over the phone at 1-509-787-5391.