Valley Health Systems
Authorization for Release of Psychotherapy Notes

VALLEY HEALTH
Quality healthcare in your neighborhood.

Patient Name Last First MI Maiden/Other

DOB Mo Day Year SS# Account #

Address City State/Zip

Day Phone (with area code) Mobile Phone Work Phone

Choose One

[ ] I authorize **VHS** to release information ***TO*:**

Name of provider or facility

Address

City, State, Zip

Phone or fax number with area code

[ ] I authorize **VHS** to obtain information ***FROM*:**

Name of provider or facility

Address

City, State, Zip

Phone or fax number with area code

Records

Release psychotherapy notes for the following dates:

Dates: _____

DATES must be filled in! Example: 2012 to 2017
"ALL" is not permitted

I understand my psychotherapy notes may include sensitive information such as reference to substance use & substance use disorder, STD/communicable disease, HIV, and genetic testing. If I wish to exclude any of this information from release, I must specify below:

Specific information **not** to be released: _____

Purpose

Information is to be released for the following purpose(s):

( ) Changing Physicians
( ) Legal
( ) Worker's Compensation
( ) Consultation/Second Opinion
( ) School
( ) Continuing Medical Care
( ) Insurance
( ) Other (must specify): _____

Note

I understand the following:

- This authorization will expire 1 year after I have signed this form.
- I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received except to the extent action has already been taken on the original request.
- The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- VHS may not condition treatment or payment on whether I sign this authorization.

Sign Here

I have had an opportunity to review the contents of this authorization. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

Signature of Patient/Legal Guardian/Authorized Person Date Witness

Records Received by Date Relationship to patient

Office Use: Date Completed: by: ID presented: Fee collected: $